PROGRESS REPORT 2009

HEALTHY **DEVELOPMENT**

THE WORLD BANK STRATEGY FOR **HEALTH, NUTRITION & POPULATION RESULTS**

THE WORLD BANK

HEALTHY **DEVELOPMENT**

THE WORLD BANK STRATEGY FOR

HEALTH, NUTRITION & POPULATION RESULTS

HEALTHY **DEVELOPMENT**

THE WORLD BANK STRATEGY FOR **HEALTH, NUTRITION & POPULATION RESULTS**

THE WORLD BANK
Washington, DC

Contents

Boxes

Figures

Tables

Abbreviations and Acronyms

AAA	Analytical and Advisory Activities
ACT	Aids Campaign Team for Africa
AFR	Africa Region
AIDS	Acquired Immune Deficiency Syndrome
AIM-AIDS	Africa Impact Evaluation for HIV/AIDS
AMCs	Advanced Market Commitments
AMFm	Affordable Medicines facility for malaria
APL	Adaptable Program Loan
ARD	Agriculture and rural development
CAS	Country Assistance Strategy
CBD	Community-based distribution
CFP	Concessional Finance and Global Partnerships
CMUs	Country Management Units
CPRs	Contraceptive prevalence rates
DEC	Development Economics
DfID	UK Department for International Development
DGF	Development Grant Facility
DHS	Demographic and Health Surveys
DOTS	Directly-observed treatment, short-course
DPL	Development Policy Lending
EAP	East Asia and Pacific Region
ECA	Europe and Central Asia Region
EmOC	Emergency obstetric care Europe and Central Asia Region
FAO	Food and Agricultural Organization
FHF	Family Health Funds
FP	Family planning
GAC	Governance and Anti-Corruption
GAVI	Alliance Global Alliance for Vaccines and Immunization
GFRP	Global Food Crisis Response Program
H8	Eight global international health agencies
HAMSET II	HIV/AIDS/STI, TB, Malaria and Reproductive Health Project
HD	Human Development
HHA	Harmonization for Health in Africa Framework
HIV	Human Immunodeficiency Virus
HMN	Health Metrics Network
HNP	Health, nutrition, and population
HNP SB	HNP Sector Board

HSPT	Health System Policy Team
HSRDP	Health Sector Rehabilitation and Development Projects
HSS	Health systems strengthening
IDA	International Development Assistance
IEG	Independent Evaluation Group
IFC	International Finance Corporation
IHP+	International Health Partnership and related initiatives
ISRs	Implementation Status Reports
ITN	Insecticide Treated Nets
LCR	Latin America and Caribbean Region
MAPs	Multi-Country HIV/AIDS Programs
MCAs	Multisectoral Constraints Assessment
MDGs	Millennium Development Goals
MeTA	Medicines Transparency Alliance
MIEP	Malaria Impact Evaluation Program
MMRs	Maternal mortality ratios
MNA	Middle East and North Africa
NGO	Non-Governmental Organization
NHA	National Health Accounts
OECD-DAC	Organization for Economic Cooperation and Development—Development Assistance Committee
OIE	World Organization for Animal Health
OPCS	Operations, Policy, and Country Services
P4H	Providing for Health
PBS	Protection of Basic Services
PDO	Project development objective
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PMI	U.S. Presidential Malaria Initiative
PMNCH	Partnership for Maternal and Newborn Child Health
PNNC	National Community Based Nutrition Program
Pop/RH	Population and reproductive health
PREM	Poverty Reduction and Environmental Management
PRSC	Poverty Reduction Strategy Credit
PRSG1-3	Poverty Support Grants Phase I–III
QAG	Quality Assurance Group
QERs	Quality Enhancement Reviews
QK	Quality and Knowledge Services
RBF	Results-based financing
RCH	Reproductive and Child Health
RCH2	India Second Reproductive and Child Health Project
RH	Reproductive Health
RTP	Reaching the Poor
SAR	South Asia Region
SDN	Sustainable Development Network
SIEF	Spanish Trust Fund for Impact Evaluation

SILs	Specific Investment Loans
SMU	Sector Management Unit
STIs	Sexually transmitted infections
SWAp	Sector-Wide Approach
TA	Technical Assistance
TB	Tuberculosis
TFR	Total Fertility Rate
TOR	Terms of reference
TST	Technical Support Team
TTLs	Task team leaders
UN	United Nations
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
WBI	World Bank Institute
WFP	World Food Program
WHO	World Health Organization

CHAPTER 1

Introduction

This document is a progress report on the implementation of the Bank's 2007 Strategy for health, nutrition, and population (HNP) results (the Strategy). The Strategy—considered by the Bank's Board of Executive Directors in May 2007—envisaged a five-year implementation window starting on July 1, 2007. This report comes 20 months into the Strategy's implementation. Progress on the Strategy's Action Plan is reported in annex 1. The progress report takes into account the recent Independent Evaluation Group (IEG) evaluation of the HNP sector. The IEG report, which covered Bank HNP activities over the period 1997–2007, emphasizes many of the same issues that had been identified in the 2007 Strategy.[1]

The 2007 HNP Strategy emphasizes strengthening of country health systems and improving the Bank's focus on results in the sector. The Strategy calls for efforts to achieve HNP results for the poor in terms of health improvements and financial protection and, as a means to those ends, strengthening health systems (HSS).[2] Weak health systems are undermining the ability of countries to achieve and sustain health results. Progress toward maternal and child health and nutrition outcomes is particularly slow because these "neglected" Millennium Development Goals (MDGs) are dependent on well-functioning health systems. There is a growing realization that countries cannot deliver basic health services through isolated interventions or through fragmented or earmarked health systems funding alone. The Strategy calls for better alignment with HSS of substantial grant funding to countries from categorical programs [for example, Global Alliance for Vaccines and Immunization (GAVI Alliance), United States President's Emergency Plan for AIDS Relief (PEPFAR), the

Global Fund for AIDS, Tuberculosis, and Malaria, the United States Presidential Malaria Initiative (PMI), and soon]. The Strategy emphasizes leveraging the Bank's unique multi-sector capacity and macroeconomic focus to improve impact and sustainability of HNP programs at the country level. It also underscores the need to improve governance, accountability, and transparency in the sector.

Several complementary developments in the international arena have impacted the sector since the Strategy's adoption in 2007. In recognition of the urgent need to improve coordination of development assistance in health, the International Health Partnership and related initiatives (IHP+) was launched in September 2007. The IHP+ responds to the Paris Declaration on Aid Effectiveness and, more recently, to the Accra Agenda for Action. IHP+ seeks to strengthen national health systems and to achieve better health results by mobilizing donor countries and other development partners around a single country-led national health strategy. IHP+ partners recognize that this approach requires substantial changes in the way donors and development actors have traditionally done business, with a simplified aid architecture, stronger civil society involvement, and a greater focus on mutual accountability that will reach far beyond the IHP+ partner countries.[3] Development partners requested the Bank, with the World Health Organization (WHO), to coordinate the work of the partnership. The Bank was also asked to co-chair the follow-up High Level Taskforce on Innovative International Financing for Health Systems, launched in September 2008, with the objective to identify and promote innovative financing mechanisms to bridge the financing gaps, identified through the IHP+ process, to attain the health-related MDGs. The Bank is also part of a group of leaders of global international health agencies (H8) that aim to collaborate and harmonize efforts to scale up health services and attain results, particularly for the poor and vulnerable.[4]

The Strategy's focus on results, especially on the poor and vulnerable, is even more relevant now, given the potential adverse impact of the financial crisis on health outcomes. Estimates indicate that, if the current financial crisis persists, between 200,000 and 400,000 more children will die every year—between 1.4 and 2.8 million children before 2015. Any reduction in investment in healthcare could have devastating consequences for the sick and untreated, and has the potential to plunge new population groups into poverty. The Bank is working closely with partners to monitor,

analyze, and mitigate the consequences of this crisis. A first report with policy recommendations has been issued. It highlights lessons learned from previous crises on how to protect health outcomes and reduce financial risk, and notes, for instance, that targeted pro-poor programs were more effective than broad-brush strategies to maintain overall levels of government health spending in protecting access and quality of services for the poor.[5]

In a flat budget environment, implementation of the Strategy has been somewhat slower than anticipated, with the bulk of the incremental resources allocated by Management for Strategy implementation available only during FY09. We have made progress in several areas, including HSS and improving the Bank's focus on HNP results, but much more needs to be done to achieve the health MDGs and to protect people from falling into poverty due to illness. Improving monitoring and evaluation, enhancing HNP's pro-poor focus, improving portfolio quality, scaling up population and reproductive health, sustaining the scale-up of nutrition, and strengthening multisectorality in HNP will be key priority areas as the sector looks forward. (See section III for staffing trends since the inception of the Strategy.)

CHAPTER 2

Progress on Implementing the HNP Strategy

The 2007 Strategy emphasizes several strategic directions: renewing the Bank's focus on HNP results, strengthening health systems and ensuring synergy between HSS and priority-disease interventions for HNP results, emphasizing multisectorality in HNP, and improving harmonization and strategic engagement with global partners. In addition, the Strategy underscores the Bank's commitment to population and reproductive health (Pop/RH) as well as nutrition, both as ends in themselves and as a means to improve other health outcomes. For ease of reference, progress against these strategic directions is discussed in the same order as presented in the Strategy.

Renewing the Bank's Focus on HNP Results

The Strategy emphasizes renewing the Bank's focus on HNP results by: tightening the linkages between lending and results via increased use of results-based financing; improving the results framework in Bank HNP operations; enhancing portfolio quality; improving monitoring and evaluation and building statistical capacity; enhancing HNP's pro-poor focus; and focusing on financial protection and risk-pooling.

Tightening Linkages between Lending and Results

A results-based financing (RBF) program, started in 2008, will expand the use of output- or performance-based financing in HNP, with a focus on MDGs 4 & 5. With support from a US$100 million trust fund

contributed by the Government of Norway, the program is increasing the learning and evidence base related to the design, implementation, and effectiveness of RBF interventions in HNP.[6] Eight countries with International Development Assistance (IDA) HNP programs are receiving incremental grant funding to develop and implement RBF mechanisms targeting the poorest segments of the population. Examples include:

- In **Benin,** the RBF mechanism will provide incentives to health facilities and health workers to boost rates of assisted deliveries among those in the poorest quintile.
- In **Democratic Republic of Congo,** the project targets some of the poorest and most isolated districts in the country and pilots RBF to providers as part of a strategy to reduce user fees, which is a prominent barrier to access for the poorest.
- In the **Kyrgyz Republic,** the program targets the quality and quantity of primary health care services, which are mostly utilized by the poor, and will also provide incentives to community-level groups to enhance awareness and increase demand for services.

Additional RBF examples are highlighted in box 1.

Impact evaluations are an integral part of each of the eight RBF projects and will assess the effectiveness of the incentive mechanisms utilized. HNP is supporting learning through workshops and a learning-based website (to be launched in April 2009) that will provide rapid access to practical knowledge, including RBF-related evidence, technical briefs, guidelines, case studies, and tools. RBF can be an important tool to address many health systems challenges by providing incentives for human resource issues, improving the timeliness, credibility, and accuracy of national monitoring and information systems, as well as providing evidence on the value of reforms that confer authority to and enhance flexibility at the local service delivery level. Although we are in the early days of the program, demand from countries to learn about RBF and begin implementation has been very strong.

Improving the Results Framework

Results frameworks in new Bank operations are being strengthened through Quality Enhancement Reviews (QERs) that focus specifically on measurement of outputs and outcomes. A new tool to monitor and

Box 1: Results-Based Financing: A Tool for Targeting Priority Health Interventions

All eight RBF program-supported projects target the poorest segments of the population. They also target reproductive and child health—the "neglected" MDGs 4 & 5—increasing the attention on interventions such as assisted deliveries and family planning services. Two examples are:

Zambia: Zambia will provide incentives at district health management, facility, and community levels to stimulate increased supply and demand of maternal and child health services. The Zambia pilot targets the poor by focusing on rural districts where over 95% of the population is below the poverty line. The first phase of the program will introduce performance bonuses for facility teams to increase outreach to underserved areas, improve technical quality, and use the skills of health workers more efficiently, as well as encourage the retention of health workers in rural facilities. Bonuses for district health management teams will be used to strengthen management and supervision of health facilities and improve availability of drugs and supplies. Bonuses for neighborhood health committees are intended to stimulate outreach and increase participation and ownership of communities in reaching key health results. The program focuses on critical reproductive, maternal, and child health services, including family planning, assisted deliveries, and iron supplementation for pregnant women.

Rwanda: The RBF program is funding the continuation of the Rwanda Poverty Support Grants Phase III (PRSG1-3), a development lending operation to improve service delivery and governance through scaling up of health insurance and RBF for health services. After four years of policy reforms and implementation, health insurance enrollment increased from 7% to more than 70%. Utilization of health services increased by more than 50%, with use of Insecticide Treated Nets (ITNs) increasing from 4% to 67%, use of family planning increasing from 10% to 27%, and assisted deliveries increasing from 39% to 52%. The health impact has been significant, with the incidence of malaria decreasing by 62% and child mortality declining by 30%. A rigorous impact evaluation shows that the results are attributable to the government's RBF program supported by the Bank, jointly with other donors. In the areas where RBF was implemented, utilization of assisted deliveries was 30% higher and use of child services 50% higher. Quality of care also improved significantly.

improve data collection, focusing on selected core sector indicators (outputs and outcomes) that will be included in project results frameworks and updated in project Implementation Status Reports (ISRs) is expected to be fully operational by the end of FY09. In collaboration with Operations, Policy, and Country Services (OPCS), IDA15 projects are being retrofitted with indicators that will allow reporting on aggregate outputs of health sector deliverables, such as the total number of health workers trained, the number of health facilities equipped or renovated, as well as the number of preventive and curative services provided.

The IEG evaluation argues for a better attribution of health outcomes to WBG-financed inputs. However, the Paris Declaration and the Accra Agenda for Action emphasize the greater development impact of pooled funding, use of country systems, and country-based monitoring and evaluation. Consistent with these principles, the Bank is working with countries and development partners to implement country results frameworks that will be used by all stakeholders. The Bank's policy on monitoring and evaluation (OP 13.60) also emphasizes the use of country-level systems. Therefore, in the future, the standard for attribution in Bank HNP operations needs to be the collection of sufficient data on outputs and intermediate outcomes in order to measure the link between Bank-financed investments and progress at the country level.

Enhancing Portfolio Quality

The HNP Sector Board continues to focus on the urgent need to improve portfolio quality. The strategy set a target of reaching 75% satisfactory project development objective (PDO) exit ratings from IEG by FY09, from a baseline of 66%. Between mid-FY07 to mid-FY09, only 52% of HNP projects that exited and were evaluated by IEG received a satisfactory rating. While portfolio performance in all regions has been lower than that of other sectors, HNP's portfolio performance in Africa is especially problematic (see box 2). The Europe and Central Asia Region (ECA), South Asia Region (SAR), Latin America and Caribbean Region (LCR), and East Asia and Pacific Region (EAP) have recently improved their performance and are approaching the strategy target of 75% satisfactory exit ratings. The current data on riskiness of the HNP portfolio confirms that the problems are most acute in the Africa Region (AFR), and that HNP's performance across most other regions is approaching that of other sectors. Contributing to the poor performance HNP's portfolio in Africa is the underperformance of projects with a significant HIV/AIDS component. A high percentage of these projects continue to receive unsatisfactory ratings from IEG[7] and constitute a disproportionate number of projects at-risk in the current portfolio (see annex 3 for additional details on the HNP portfolio).

Financial resources and incentives for proper supervision of Bank HNP projects, particularly in challenging areas such as HIV/AIDS and fragile states, are a priority going forward. Supervision is critical for delivering on PDOs. While supervision budgets for Bank HNP projects

Figure 1: IEG Outcome Ratings by Region mid-FY07 to mid-FY09

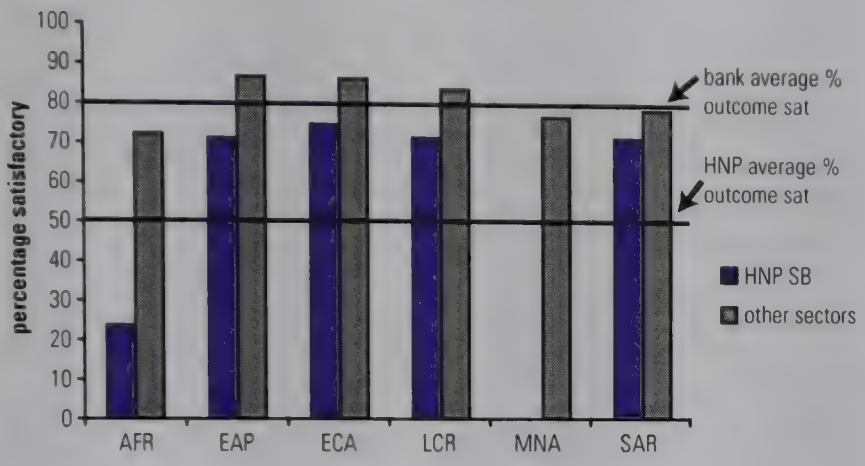
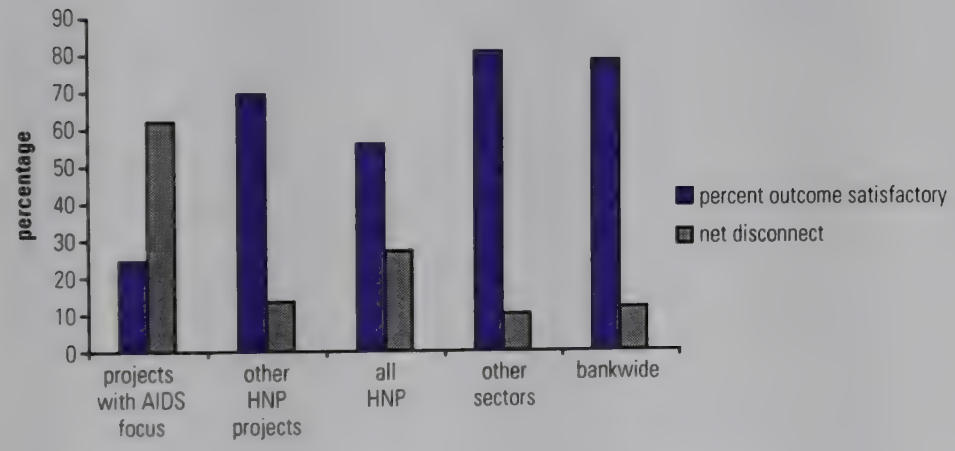


Figure 2: IEG Ratings for FY06–08 Exits8



vary by region and by country, data shows the distinct need for increased resources, particularly to ensure adequate supervision of risky or problem projects (see annex 4). Problem projects and projects in fragile states generally require higher supervision budgets invested over a longer term. In a flat budget environment, regions have not always been able to replace Consultant Trust Funds, which previously funded up to a third of the supervision budget before their phaseout. As noted during the recent Board discussion of investment lending reform, the provision of adequate implementation support during supervision, especially in high-risk situations and in

sectors such as HNP that require proactive support, is one of the immediate priorities of the reform effort.[9]

The Bank's programmatic support and the proposed reform of investment lending have the potential to increase the focus on implementation and results, and reduce the focus on transactions. The proposed reform of investment lending will help place greater emphasis on results and the supervision and implementation support needed to attain and monitor such results, expanding the focus beyond disbursements and their links to inputs.

Management is undertaking significant remedial actions to improve HNP's portfolio performance. In March 2008, the HNP Sector Board (HNP SB) asked the Quality Assurance Group (QAG) to review the performance of HNP projects that were categorized as being at-risk, as well as those considered to be good candidates to benefit from additional quality enhancement efforts. The QAG panel's recommendations included: strengthening sector management oversight; reviewing current resources for preparation/supervision; and addressing two key weaknesses—monitoring and evaluation and institutional analysis. The report also expressed concern about the declining attention being paid to family planning and nutrition in countries that should be scaling up these activities.[10]

In response to the QAG recommendations and an internal portfolio review, the HNP SB is implementing a detailed Portfolio Improvement Action Plan which is being monitored on a quarterly basis.[11] It is aimed at all at-risk projects, as well as projects needing additional management oversight to avoid falling into at-risk status and addresses the key recommendations in the various reviews (see above). The Plan also involves a thorough risk analysis of each region's portfolio and suggests measures to introduce risk mitigation as well as identify projects not currently at risk, but need more attention to improve their performance. For instance SAR is dedicating staff to undertake a critical assessment of the results frameworks of the HNP portfolio, paying particular attention to monitoring and evaluation during preparation and supervision. Middle East and North Africa (MNA), with intensive management involvement and increasing effort over the past six years, has drastically improved portfolio performance.

Special efforts are being undertaken to support AFR and HIV/AIDS programs. AFR has implemented several changes aimed at improving HNP's portfolio in the region (see box 2). AFR is also receiving additional technical and financial support through the Health Systems for Health MDGs program (paragraph 30), which will address many of the

Box 2: Improving Africa's HNP Portfolio Performance

Why has the HNP portfolio in AFR been performing poorly?

- The low performance is largely attributable to the Multi-Country HIV/AIDS Programs (MAPs) Program.
- Donor coordination may be weak, fragmented, and insufficiently focused on country needs, which is part of the rationale for the creation of IHP+.
- The sector has a high proportion of recurrent costs (e.g., human resources and drugs) relative to investment costs. Specific Investment Loans (SIL) have often been used to support pharmaceutical procurement, but sectoral Development Policy Loans (DPL) are probably more appropriate. New instruments and future projects will focus on channeling resources to frontline provision, monitoring results, and strengthening voice and accountability.
- HNP holds itself accountable to very ambitious goals. Health outcomes depend on multiple inputs (recent work shows that the HNP sector needs more than 900 basic essential inputs while education needs less than 200), and are often also dependent on inputs from other sectors such as education, water and sanitation, and agriculture.

The Region has developed new strategic approaches to improving portfolio quality:

- The Africa Human Development (HD) and Quality and Knowledge Services (QK) Departments jointly developed a "Results Chain" tool which defines a clear results framework with key indicators, to allow task team leaders (TTLs) to improve the selection and monitoring of their outcome indicators. All new projects will use this chain for their PDOs and other portfolio results indicators monitored.
- A new regional HNP Strategy is under development, in line with the 2007 HNP Bank-wide Strategy. This Strategy calls for a focused approach on health system strengthening, multisectoral approaches to achieving results, and greater use of sectoral DPL or Protecting Basic Services (PBS)-type instruments.
- HD Africa will reorganize to create a unit which will manage the entire HNP portfolio (expected July 2009), improving the focus on technical synergies and coordination, transparency, and accountability.
- Africa's technical capacity in HNP is being significantly strengthened with the establishment of the new Dakar and Nairobi HSS hubs and the recruitment of ten high-level expert staff. New staff with strong technical skills in health systems, health economics, and nutrition have been recruited.

Regional Management is also undertaking extensive remedial actions on the portfolio:

- The Sector Management Unit (SMU) and Country Management Units (CMUs) have tightened reviews and follow-up actions on the last two ISRs ratings.
- Task Teams are carrying out early restructuring to revise ill-defined PDOs, using results frameworks designed and adopted by HD.
- MAPs are being restructured.
- Regional action is being sought on country and effectiveness flags that are not directly related to project implementation. Additional resources are being provided to supervise Unsatisfactory/Moderately Unsatisfactory and Moderately Satisfactory projects and also tap extra resources to bolster task budgets for supervision, e.g., Aids Campaign Team for Africa (ACT Africa), Technical Support Team (TST), Malaria Team, etc.

weaknesses identified in the various reviews. A comprehensive approach has also been adopted to improve the quality of HIV/AIDS projects, which included an umbrella restructuring package of 11 MAPs for Africa projects in FY07. Moreover, efforts are being made to provide additional technical support to improve implementation, develop impact evaluation capacity, as well as strengthen governance and accountability within national AIDS programs.

Improving Monitoring and Evaluation and Building Statistical Capacity

The HNP SB, in line with IEG recommendations, is taking steps to reduce and manage complexity of HNP operations. The analytical underpinning, political mapping, risk and institutional assessments, and project results frameworks are being improved. However, HNP operations are rarely institutionally or technically simple, since the desired outcome depends on a complex and interacting set of social, cultural, cross-sectoral, and institutional factors. Client governments and development partners all recognize that monitoring and evaluation is especially challenging.

Monitoring and evaluation is being improved and activities aimed at strengthening statistical capacity in HNP are being implemented, but much remains to be done. The Bank has deepened its collaboration with the Health Metrics Network (HMN), a global partnership aimed at building statistical capacity in countries to improve the collection and use of health information, through Development Grant Facility (DGF) support to HMN. This effort is well aligned with the work on country results frameworks under the IHP+ (see also paragraph 34).

HNP and its partners are developing indicators to monitor health systems, including those related to measuring quality of care. With the support of the Governance and Anti-Corruption (GAC) trust fund, HNP is piloting in five countries a toolkit to measure health system governance to better monitor accountability in the sector. The Bank is also working with partners to develop better ways to monitor the health MDGs, including the estimation of trends in child and maternal mortality, for which updates have recently been issued. Additional examples of improvements in monitoring and evaluation are described in box 3.

In partnership with WHO and others, the Bank is designing a monitoring framework to help countries track health expenditures

Box 3: Improving Monitoring and Evaluation in HNP

- One of the largest impact evaluation trust funds at the Bank, the **Spanish Trust Fund for Impact Evaluation (SIEF),** is housed in the HD sector. The trust fund, which was initiated in 2007 and will continue until 2010, finances rigorous impact evaluations of interventions aimed at enhancing human development, as well as learning and dissemination activities to help promote knowledge and awareness of "what works?" in the HD sector. Currently, the trust fund is financing impact evaluations in 15 HNP projects across all regions, focusing on results-based financing, malaria control, provider-payment reforms, and HIV/AIDS prevention.
- **Argentina's** *Plan Nacer,* which is a Bank-supported provincial maternal and child health insurance program, has been an effective results-based financing intervention aimed at improving the coverage of a defined package of maternal and child health interventions among the uninsured in the country. Phase I of Plan Nacer has reached 527,305 beneficiaries and, after just one year of Phase II implementation, coverage has been extended by an additional 388,118 beneficiaries. Every four months the program monitors ten strategic health indicators that are related to maternal and child health outcomes track the progress of program implementation. The scaling up of the program to other parts of the country has also stimulated the strengthening of the country's health management information system, providing critical information for targeting and measuring HNP results in the country.
- The Africa Region has pioneered work by the **Africa Initiative on Impact Evaluation**. There are four streams of Impact evaluation. Their objectives are to generate knowledge, secure the quality of our operations and their development impact; and support client institutions and strengthen their capacity for rigorous evaluation and evidence-based policy making.
  - The Africa Impact Evaluation for HIV/AIDS (AIM-AIDS) covers 21 country cases with 6 impact evaluations ongoing and 17 in preparatory stage.
  - The global Malaria Impact Evaluation Program (MIEP) covers 7 countries (6 in Africa plus India). The evaluations are ongoing.
  - The Health RBF impact evaluation covers 6 countries (5 in Africa). The evaluations are in preparatory stage.
  - The SIEF Health contracting cluster covers 5 country cases (2 in Africa)
- In order to improve the monitoring of health system resource flows, a program on institutionalization of **National Health Accounts (NHA)** has recently been launched in collaboration with WHO. The two-year program—funded by the Bill & Melinda Gates Foundation—focuses on developing a global strategic action plan to promote the institutionalization of NHA in low and middle-income countries. NHA data are a key metric of any health system in that they provide a full mapping of resource flows within the sector, providing key information on sources and uses of health funds. The project will identify key constraints to institutionalization of NHA and finance a set of discrete interventions to overcome some of these constraints in four pilot countries. Lessons learned from these pilots will be widely disseminated and will feed into informing an action plan to institutionalize NHA in additional countries.

and other critical inputs for health outcomes. Measuring expenditures on health is a complex task, since governments in low-income countries typically do not report expenditures on a timely and regular basis. Monitoring budgets alone is insufficient, since budgets are often not fully realized. Measuring specific inputs for outcomes, such as number of lower-level facility staff, availability of essential drugs and supplies, financial support for transport, working readiness of medical equipment at lower level facilities, and so forth, can provide valuable insight to the functioning of the health system.

Enhancing HNP's Pro-Poor Focus

The Strategy explicitly recognizes the need to focus on HNP outcomes among the poor. The Strategy drew heavily on the Bank's path-breaking Reaching the Poor (RTP) program, active since 2001. RTP has provided global leadership in the measurement of disparities in HNP health service coverage and outcome indicators among the poor versus the non-poor, as well as of the financial burden on households of seeking care. These data, and the methods developed to generate them, are now widely cited and adopted.[12] In 2005, RTP published a review of projects that had been successful in reaching the poor in "Reaching the Poor with Health, Nutrition, and Population Services: What Works, What Doesn't, and Why." A new report, "Attacking Inequality in the Health Sector: A Synthesis of Evidence and Tools," was launched in January 2009. This volume lays out a policy menu emphasizing pro-poor policy reform along six dimensions, and a list of the analytical tools to better understand the constraints to pro-poor targeting of public health investments (see box 4).

An example of a country application of the RTP work is the investigative study of utilization of health services and patient satisfaction for the poor in selected states in India, which led to a range of reforms including management training, new staffing and service patterns, provision of essential drugs, and repair of equipment and facilities. This program resulted in increased utilization of all types of health facilities (improving absolute levels of utilization among the poorest 40 percent of the population) and improved patient satisfaction at lower-level project facilities (as opposed to hospitals) for the poor.

The analytical basis for further effort in the area of improving the pro-poor focus in HNP programs is now strong, due in part to the RTP program and other related work completed in the last several years. The

Box 4: "Attacking Inequality in the Health Sector: A Synthesis of Evidence and Tools"

Building upon the RTP work, Attacking Inequality in the Health Sector provides a list of policy options to design targeted interventions for reducing inequality within the health sector in developing countries. Specific lessons are drawn from Brazil, Cambodia, Chile, Colombia, India, Indonesia, Kenya, Kyrgyz Republic, Mexico, Nepal, Rwanda, and Tanzania. The authors recommend the following six rules of thumb in implementing successful pro-poor policies in HNP:

Health Sector Finance Reforms

- Delink payment from utilization of health services by the poor at the point of service delivery.
- Make the money follow the poor.

Health Sector Provider Payment Reforms

- Link provider payment to utilization of health services by the poor.

Health Sector Organizational Reforms

- Reduce the distance between the poor and services.

Health Sector Regulation Reforms

- Amplify the voice of the poor.

Health Sector Persuasion (Behavior Change) Reforms

- Close the gap between need and demand by the poor.

HNP SB will convene a working group to take forward the operational implications of the RTP agenda before the end of FY09. The proposed terms of reference (TOR) of the working group will be to:

- Identify selected countries and Bank-supported operations to assess performance in reaching the poor, improve capacities to identify and target poor beneficiaries, and monitor changes in their access to priority services.
- Prepare a proposal for internal or external funding to support additional technical work and capacity building linked to specific Bank operations to enhance reaching-the-poor efforts in HNP operations.
- Scope out and start a multi-year program of work between HNP and the World Bank Institute (WBI) to provide relevant analytical work, evaluation research, and training for Bank staff and clients related to operationalizing the RTP agenda.

Focus on Financial Protection and Risk-Pooling

As emphasized in the Strategy, mitigating the risk of impoverishment due to health shocks is an important objective of a health system. However, even if people do not become impoverished as a result of unexpected health expenses, household welfare can be improved through the introduction of formal risk-sharing arrangements. The Bank is actively engaged in this area in several countries. Ongoing analytical work on health financing in Indonesia aims to inform the government's proposed implementation of universal health insurance coverage. The 2009 Bank publication, *Health Financing and Delivery in Vietnam: Looking Forward*, compares scenarios on how to increase insurance coverage to 100% of the population, as well as how scaled-up coverage can further reduce out-of-pocket spending on health care. In the same vein, a new lending operation on health sector reform in China involves expanding and deepening health insurance, provider payment reform, and improving incentives and accountability in public health in the country. The Bank is also part of "Providing for Health (P4H),"[13] an international forum for dialogue and collaboration on the health systems financing issues in poor countries.

HNP has also been actively engaged in measuring and estimating the impoverishing effects of illness, since the 2006 book, *Beyond Survival: Protecting Households from Health Shocks in Latin America*, which highlights the importance of financial protection for households and the risk of impoverishment from health shocks, with case studies of Argentina, Chile, Colombia, Ecuador, Honduras, and Mexico. Evidence of the effects of health expenditure on consumption and poverty in low- and middle-income countries has also been highlighted recently for Vietnam,[14] the Western Balkans,[15] India,[16] and China.[17] The recent Bank publication, *Analyzing Health Equity Using Household Survey Data*, describes the methodology used to analyze the impoverishing effects of health expenditure in an accessible manner. Accompanying the publication are editable software programs that make it easy to conduct health equity analyses. These are being used by the Regions, as well as others outside the Bank.

Strengthening Health Systems for HNP Results

The Strategy underscores the need to focus on health systems for delivering improved HNP results, particularly for the poorest and the most vulnerable. It is now globally accepted that HSS is critical for attaining HNP

results. Notwithstanding the many implementation challenges, major shifts at the programmatic and organizational level are now taking place.

Over the past two years, projects with a primary focus on health systems have increased. An additional 13 health systems-focused projects are in the pipeline for FY10 (see annex 5 for more on HSS programs). In line with the strategy, 67 percent of Bank programs approved since FY07 that focus on priority disease areas also include strong components on HSS. The Bank's technical and analytical work on HSS has also been strengthened (see Box 5) and in FY09, 40 percent of Country Assistance Strategies targeted HNP results and identified capacity and systems building activities.

The Bank is working with partners to provide strategic leadership in advancing HSS for improved HNP results, in line with the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action. The Bank has long been engaged in health systems for results in middle-income countries. With its development partners, the Bank is now actively enhancing its efforts to strengthen health systems for results in low-income countries, supporting a new framework for global partnership in health via IHP+, implementing innovative approaches to use financial incentives to generate desired health results at national and sub-national levels through RBF mechanisms, and using *results-oriented Sector Wide Approaches (SWAps)* to strengthen country ownership and harmonization and alignment of development partners. HNP is also working with IFC, in particular in AFR, to leverage existing private sector service delivery channels in helping to improve health outcomes for the poor.[18]

A new Health Systems for the Health MDGs program was launched in late 2008 to fund and implement coherent country-led health sector programs in Africa, beginning with the 14 IHP+ countries. The program is increasing on-the-ground technical assistance and coordination of partners to better support national strategies.[19] The establishment of two regional HSS hubs in Africa (in Dakar and Nairobi) and recruitment of ten high-level experts with a strong health systems focus will be completed by the end of FY09.[20] This program will improve the Bank's ability to rapidly assist and advise HNP operations on the ground, particularly in the areas of health finance and risk-pooling mechanisms, human resources for health, governance, supply chain management, as well as infrastructure planning. It signals a change in that the Bank will provide additional support for analytical and policy work, as well as implementation, to client countries and bilateral and multilateral partners, even when IDA may not be lending for health in a given country. Working closely with all recent initiatives (including

Box 5: Highlights of Recent Scaling-Up of HSS Activities

Operational Activities

- In **Democratic Republic of Congo,** a newly approved US$16 million **Health Services Development Project** will support the strengthening of health systems to effectively combat some of the major communicable diseases and improve access to quality services for women, children, and other vulnerable groups.
- The **Russian national program to arrest the growth of tuberculosis (TB) and HIV/AIDS** among civilians and prisoners over 2004–08 improved access to quality health services, including development of standards and guidelines for prevention, diagnosis, and treatment of patients. The program has strengthened laboratory capacity for better diagnosis and patient follow-up, improved the provision of drugs, trained personnel, and strengthened the epidemiological surveillance systems.
- In **Kazakhstan,** a newly approved US$78.9 million health sector reform project will introduce international standards and build long-term institutional capacity in the Ministry of Health and other institutions involved in health service delivery to support key HNP objectives identified by the government.
- As part of the **Turkey Health Transformation and Social Security Reform Project,** a number of pilots of output-based financing mechanisms for preventative health care services are being taken forward, financing per-capita payments to family medicine practices for preventive health care interventions for the control of noncommunicable diseases.
- An assessment of pharmaceutical governance has been carried out in Peru through the project **Addressing Corruption in the Pharmaceutical Sector.** It identified specific proposals to measure and improve transparency and strengthen efficiency and control over public expenditure, procurement, and logistics management of essential medicines. As a result, Peru is one of the first **Medicines Transparency Alliance (MeTA)** pilot countries (see below) and work has been taken forward to create a medicines prices observatory.

Technical Assistance (TA) and Analytical and Advisory Activities (AAA)

- Phase I (2006–08) of the Bank's work program on **Strengthening Human Resources for Health Policy in Developing Countries** has focused on labor market dynamics, fiscal constraints analysis, and costing analysis. Phase II of this work program will build upon the success of Phase I, while creating linkages to both IHP+ and RBF through a results, innovation, and knowledge-generation focus.
- Pilot case study analyses for Indonesia, Uganda Rwanda, and India and development of guidelines for **fiscal space assessments** for health are ongoing. Fiscal space assessments in health contextualize the macroeconomic underpinnings of government health spending, identify possible avenues for overcoming financial constraints to scaling up health systems, and inform policy dialogue related to health financing more generally.

(continues on the following page)

Box 5: (continued)

- The Bank, in partnership with the UK Department for International Development (DfID) and WHO, has been a leader in **MeTA.** With the overall goal to improve access to medicines by increasing transparency and accountability in the health marketplace, the Bank and partners are currently focusing on seven countries (Ghana, Jordan, Kyrgyz Republic, Peru, Philippines, Uganda, and Zambia). Active programs are ongoing in Ghana, Jordan, and the Philippines and include activities such as training in selection of drugs for formularies, a study for optimization of supply chains, development of e-procurement systems, assessments of drug quality, and development of plans for drug quality monitoring systems.
- HNP is expanding and improving capacity-building activities via WBI's ***Flagship Program on Health Sector Reform and Sustainable Financing*** (to be renamed *Health System Strengthening*). A recent review reports that more than 18,000 people (mainly individuals from client countries) have passed through some type of flagship program-related training. The program is slated for updating in FY09 and WBI has identified this as a core area in their new focus.
- A **Health Systems Thematic Group** has been relaunched and a new **Health Systems Global Expert Team** has been convened with the objectives of identifying and developing in-house expertise and sharpening the focus and ability of the Bank to address health systems issues.
- The Bank has also made significant contributions through recent analytical work related to HSS, with several publications related to health financing and health systems completed in the past two years:
  - *Good Practices in Health Financing*—a detailed analysis of nine country case studies that have been successful in expanding access to essential health services and financial protection for the poor.
  - *Social Health Insurance Governance and Regulation,* which focuses on lessons learned from the analysis of governance of social insurance in four countries.
  - *Regulating Private Health Insurance,* which develops detailed guidelines for the regulation of voluntary/private health insurance in developing countries.
  - *Health Service Delivery*—a comprehensive review of innovations and strategies pursued in the reform of health service delivery in a selection of countries.
  - *Overcoming Fiscal Constraints to Scaling-Up Health Workforce Capacity in the Public Sector,* which reviews the experience of selected country case studies on overcoming fiscal constraints to scaling up the health workforce.

GAVI and Global Fund HSS), this is being implemented in strong partnership with the H8 organizations and the Harmonization for Health in Africa Framework (HHA).[21]

Emphasizing Multisectorality in HNP

Multisectorality in HNP needs to be actively supported and mainstreamed in the Bank, given the interdependence of health outcomes on several other key sectors. The Strategy noted a comparative advantage for the Bank in multisectoral approaches to HNP results, linked to our unique country dialogue across many sectors, our engagement with clients in finance and planning, and strong technical capacities in different areas. The HNP sector already engages widely with other sectors, contributing to HNP-related outcomes in projects in transport, agriculture and rural development (ARD), water and sanitation, social protection, and others. An example is MNA's efforts towards closer coordination between social security and social insurance reforms, as elaborated in box 6. Nutrition programs have also lent themselves to multi-sectorality, entailing collaboration with ARD on biofortification, social protection programs, and early childhood development. (box 6). About 45% of HNP's lending in FY09 was through other sectors, and this is projected to increase in the future (see annex 3).

HNP outcomes depend on multisectoral inputs and HSS requires a strong cross-sectoral focus. For this reason, the Strategy called for the development, piloting, and implementation of a multisectoral constraints assessment tool as well as the formation of a Bank-wide intersectoral thematic group. Budget constraints have delayed this work, which is expected to begin in FY10 (see annex 1).

Improving Harmonization and Strategic Engagement

All development partners recognize the urgent need to do more and better in global health and to improve outcomes at the country level. The Bank is maximizing the positive impacts of its analytical and operational work in key areas of its comparative advantage by engaging in strategic partnerships and division of labor. In the last two years, the Bank has played a pivotal role in taking forward the partnership agenda, working with WHO to coordinate IHP+.[22] IHP+ is on track to deliver on its Phase I objectives, which include: (a) harmonizing planning, financing, and monitoring of HNP results at the global level; (b) developing common country health sector results frameworks; (c) designing a joint assessment tool for country health plans; (d) establishing cross-agency agreements on civil society engagement; and (e) completing the first independent review of the IHP+ process.

Box 6: Examples of Multisectorality in HNP

- The **Ethiopian Protection of Basic Services** program is a multisectoral SIL focusing on the delivery of basic services, including education and health. The project transfers funds directly to local governments based on needs and performance criteria. A federal fund—the *MDG Performance Fund*—was also established to ensure the financing of public goods such as vaccines. As part of this project, more than 20 million ITNs were distributed and more than 24,000 health extension workers—female 10th graders trained in one year to provide services in their village—were deployed. After two years, there is evidence that malaria incidence decreased by more than 40% in the country.
- The **Madagascar Second Community Nutrition Project** is a multisectoral SIL focusing on community behavior change of mothers. The key development objective is to improve nutritional status, especially for children and mothers, and ensure long-term sustainability of nutrition outcomes by improving the quality and quantity of food intake by children at home. The project has four components: (a) overall nutrition, provision of food and vitamins; (b) provision of iron supplement and deworming for children in schools; (c) inter-sectoral activities between health and agriculture to disseminate guidelines for agricultural diversification and product storage; and (d) project management. The project has been ongoing for several years, but recent additional financing for its core activities has resulted in significant achievements. An impact evaluation conducted in 2006 showed that after two years of being enrolled in the National Community Based Nutrition Program (PNNC), there was a 10% reduction in underweight in malnourished children under three. Madagascar is now one of few countries on target to attain the nutrition MDG.
- The **MNA region** has supported a coordinated approach between health insurance reforms and **social safety net/social targeting reforms**. For example, in **the Arab Republic of Egypt** the Bank is supporting a government pilot program which is applying the new social targeting mechanisms (proxy-means testing) developed by the Ministry of Social Solidarity to the new health insurance registration and enrollment scheme. The process is intended to improve the identification of the poor, who will be exempted from premium contributions and copayments, and ultimately, to improve financial protection of the citizens. The program's success depends on the effectiveness of the new social targeting mechanism, and requires close coordination with the social protection team.
- HDN and SDN have worked closely along with other international technical agencies (FAO, OIE, WHO, UNICEF) to support the development of a **strategic framework for reducing risks of infectious diseases at the animal-human-ecosystems interface**, such as Avian Influenza.

Three IHP+ country compacts[23] have been signed (Ethiopia, Mozambique, and Nepal) and four more will be signed by the end of 2009. The next phase will focus on tangible results at the country level by strengthening health systems, making domestic and international funding for health more predictable, coordinating international support for national

health plans, and ensuring mutual accountability of national and international stakeholders in line with the Paris Declaration and the Accra Agenda for Action. The most critical indicator of this success will be progress in expanding services and achieving health-related MDGs in IHP+ countries. IHP+ partners recognize that the next phase requires a sea change in the way donors and development actors have traditionally done business, with a simplified aid architecture, stronger civil society involvement, and a greater focus on mutual accountability.

The Bank is actively engaged with other global leaders of health organizations, focusing on division of labor and strengthening collaboration in order to achieve better health outcomes in developing countries. The Bank is a part of the newly formed (July 2007) informal partnership of the heads of eight health agencies (H8), which meets biannually to strengthen linkages and work jointly to address challenges to scaling up health services and improving health-related MDG outcomes, particularly for low-income countries. The H8 partnership is the first of its kind in health, emphasizing the need for increased cohesion in the global health aid architecture. A key product of this informal partnership was a global common results framework for health, which was agreed in FY08. The Bank is also an active member of several other health partnerships, such as the GAVI Alliance, Global Fund, Roll Back Malaria, and the Partnership for Maternal and Newborn Child Health (PMNCH).

A High Level Taskforce on Innovative International Financing for Health Systems has been established and is co-chaired by the UK and the Bank.[24] The objective of the Taskforce is to contribute to filling national financing gaps, identified through the IHP+ process, to reach the health MDGs through mobilizing additional resources, increasing the financial efficiency of health financing and enhancing the effective use of funds. In time for the July 2009 G8 Summit in La Maddalena, Italy, the Taskforce will: (a) make recommendations on the mix of innovative international financing mechanisms needed to deliver the extra resources required; and (b) promote international support for these recommendations to ensure they are implemented. The Taskforce meeting on March 13, 2009 discussed various financing options and highlighted in particular: (a) tax and levies, including the existing Air Ticket Levy; (b) frontloading, including expanding the existing International Finance Facility for Immunisation to broader health systems; (c) approaches to increase voluntary contributions; (d) leveraging in resources and expertise from non-state actors, including

the private sector; and (e) mechanisms to enhance markets, such as Advanced Market Commitments (AMCs).[25]

In recent years, the Bank has supported several additional innovative financing mechanisms. For example, the AMCs program is designed to create market incentives for the rapid production scale-up and introduction of priority vaccines, beginning with a pilot for the pneumococcal vaccine (to be discussed by the Executive Directors at the end of March 2009).[26] The Bank was one of the early supporters of the Affordable Medicines Facility for malaria (AMFm), which will accelerate the rapid global introduction of artemisinins.[27] The Bank continues to be an active player, both as convener and participant, in these and other global financing and other initiatives with a commitment to harmonizing and enhancing the effectiveness of the global aid and health financing architecture.

The Bank is working with several development partners, notably WHO, the Global Fund, and GAVI Alliance to build and strengthen relationships and set standards to enact the principles outlined in the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action. The use of health as a tracer sector in monitoring the implementation of the Paris Declaration was endorsed at a workshop held by the Organization for Economic Cooperation and Development—Development Assistance Committee (OECD-DAC) in December 2006. Following this, and in the lead-up to the Third High Level Forum on Aid Effectiveness in Accra in 2008, the Bank has developed and implemented a collaborative work program with WHO, resulting in joint leadership in and management of IHP+ and the High Level Taskforce on Innovative International Financing for Health Systems. The Bank has started work with the Global Fund and GAVI Alliance to harmonize funding for HSS at the country level.

The Bank has recently reached agreement with UNICEF on the use of a procurement template, to be used by the Bank's borrowers when UNICEF provides them with health goods and related services financed by the Bank. A similar procurement arrangement with UNFPA will be signed by May 2009. The Bank is taking steps to design similar templates with other UN agencies, with a high priority being accorded to procurement related to TB.

The Bank is the current chair for the PMNCH. PMNCH brings together international organizations, UN partners, foundations, bilaterals, and professional organizations to provide advocacy and advice on these issues, with a specific focus on the continuum of care for maternal and child

health. Since MDGs 4 & 5 are so closely linked, a strong focus on an integrated health systems approach which can deliver a package of services in nutrition, maternal, and reproductive health, and care for newborns, is needed. The Bank is also one of the four signatories of the UN Joint Statement on Maternal and Neonatal Health through which, together with UNFPA, UNICEF, and WHO, the Bank will initiate dialogue with governments to ensure that MDG 5 is reflected within national health plans, including IHP+ compacts, and that it is translated into action on the ground (see also section F).

Nutrition

Building on the Bank's work on *Repositioning Nutrition as Central to Development* publication, the Strategy highlights the importance of nutrition both as an outcome in itself, as well as a constraint to achieving other health outcomes, especially MDGs 4 & 5.[28] Reduction in malnutrition—the non-income face of poverty (MDG 1c)—has been slow over the last decade. The recent food and financial crises, which are estimated to have added an additional 44 million malnourished individuals, underscore the importance of improving nutrition outcomes and safeguarding against increases in undernourishment in vulnerable populations.[29] As the implications of the current crisis unfold in the poorest countries, the malnutrition situation is expected to deteriorate further.

An ambitious agenda is being implemented for scaling up the nutrition portfolio and correcting the declining trend in the Bank's investments in nutrition.[30] The agenda for scaling up nutrition is being catalyzed with additional budget resources for 2009–12.[31] These catalytic resources are programmed primarily for rebuilding the Bank's own staffing capacity to respond to the needs in high-malnutrition burden countries, principally in Africa and South Asia. Some of the funds will also be used in Latin America to pilot innovations in service delivery. These funds will be complemented by additional trust fund resources from Japan, and possibly from other donors that are currently engaged in discussions on this issue. These catalytic funds are also being used to develop a shared global action plan for scaling up nutrition, strengthening partnerships with key players such as UNICEF, World Food Program (WFP), WHO, and the private sector, and to help rebuild the global nutrition aid architecture.

Box 7: From Mitigation to Prevention: Scaling Up Nutrition Interventions

The **Senegal Nutrition Enhancement Project** is a second Phase Adaptable Program Loan (APL) (2007–11) which follows a successful first Phase (2002–06). These Bank-supported programs have enabled the government to design and implement innovative national results-based health and nutrition programs that act at the community level through a collaboration arrangement between local governments, health districts, and civil society organizations. The programs involve grandmothers, pregnant women, and religious leaders, among others. Results from Phase I show that antenatal care increased by almost a third to 67%, exclusive breastfeeding rates nearly doubled to 58%, and the correct use of bed nets more than doubled to reach 59%. In the intervention areas, malnutrition dropped by half to just 10%. An independent impact evaluation showed that the results are attributable to the program. The second phase will see the program scaling up nation-wide to cover half of the child population in the country. The program also promotes nutrition-relevant service delivery in health and education, implements the national food fortification Strategy, and is developing a child-focused social cash transfer program. After a decade of stagnation during the 1990s, malnutrition has come down from 22% to 17%, thereby bringing Senegal within reach of achieving the nutrition MDG. Similar programs are under consideration in other countries.

Population and Reproductive Health

Strengthening population and reproductive health using a health systems approach is critical to maternal and child survival. The 2007 Strategy reaffirms its commitment to the MDGs 4 & 5 by highlighting maternal health and family planning in health systems. Two regions in particular, Sub-Saharan Africa and South Asia, continue to face high maternal mortality ratios (MMRs). In Africa, in addition to the HIV/AIDS epidemic, high MMRs and persistently high total fertility rates (TFR>5) are of concern.[12]

Poverty and high fertility are closely correlated. Recent research demonstrates that fertility rates have an important bearing on poverty reduction. Bank studies have shown that the poor are often bypassed by the public sector basic services, including education and reproductive health services.[11] Wealth asset quintile data from demographic and health surveys (DHS) indicate that the poor have higher TFRs than the rich across countries in all regions. A similar pattern is seen in the utilization of family planning services, where the poor have lower contraceptive prevalence rates (CPRs) than the rich.

Insufficient attention has been given to family planning in recent years by the Bank. A recent Management review of the Bank's lending

shows that Pop/RH lending has not sufficiently focused on the 35 high fertility countries (figure 3). With the advent of the International Conference on Population and Development and the accompanying broadening of the definition of reproductive health and rights since the mid 1990s, the Bank has continued to finance a broader range of projects that address different aspects of the reproductive health agenda, but with a less specific focus on the delivery of family planning services. The review also noted that globally, the specific focus of family planning services—commodities, training, and information—has taken a back seat to the competing demands of other reproductive health needs, in particular HIV/AIDS.

Figure 4 shows HNP's lending portfolio (ongoing and pipeline projects) on population and reproductive health. Most of the Bank's lending for population projects is directed at Sub-Saharan Africa and South Asia; the two high priority regions (see annex 6 for examples of Bank-supported projects in Pop/RH). Currently, there are 24 HNP projects with a Pop/RH component in the pipeline. The Bank's total commitment towards these projects is US$317.6 million, with an additional US$13.3 million in grants. Six projects have family planning incorporated within their project

Figure 3: Bank Lending to Pop/RH: New Commitments Worldwide and in 35 High-Fertility Countries, FY94–08

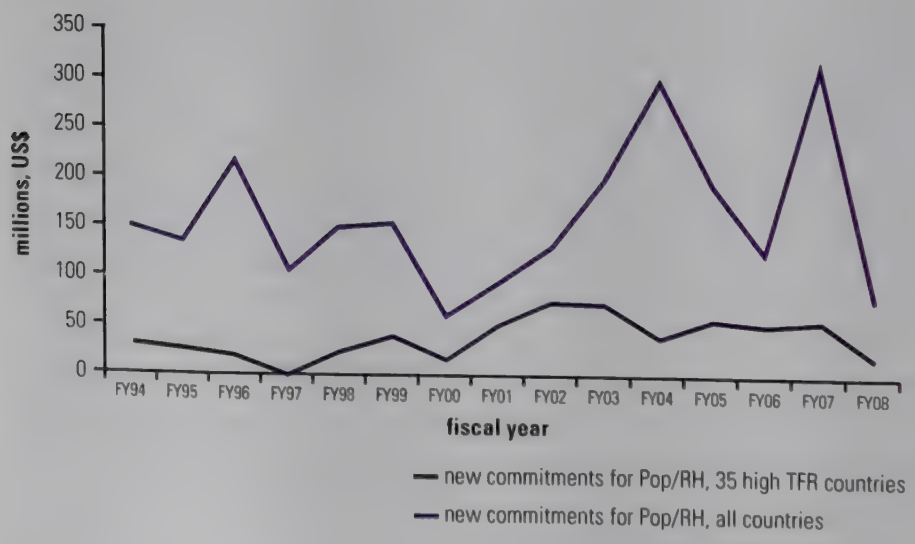
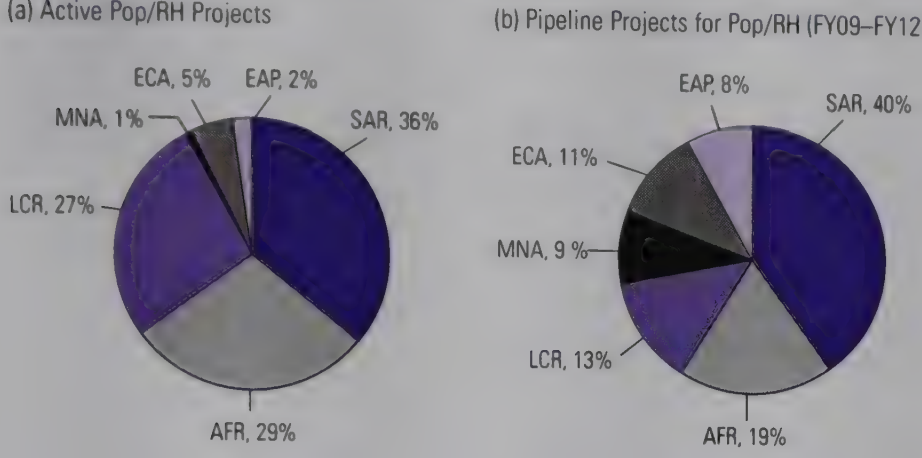


Figure 4: Active and Pipeline Pop/RH Projects



components. These projects will be executed in Burundi, Chad, Madagascar, Sierra Leone, Djibouti, and Yemen. Of the remaining 18 pipeline projects, 5 do not yet have their project information documents.

Bank lending has targeted AFR and SAR, the two most vulnerable regions (annex 6). However, projects in these high MMR and TFR countries require greater emphasis on family planning, use of skilled health personnel at delivery, and use of emergency obstetric care. These issues are now well recognized internationally and the Bank, as co-chair, is working with partners in the High Level Task Force on International Innovative Financing (paragraph 36), to identify, cost, and implement the most effective packages of interventions, including for reproductive health. In the light of this, inhouse capacity and skills in this area will be strengthened with a special focus on the Africa and South Asia Regions (and the newly created hubs in Africa) to provide high-level technical support to implement the recommendations of the Taskforce. Management will report back to the Board of Executive Directors on progress in this critical area by December 2009.

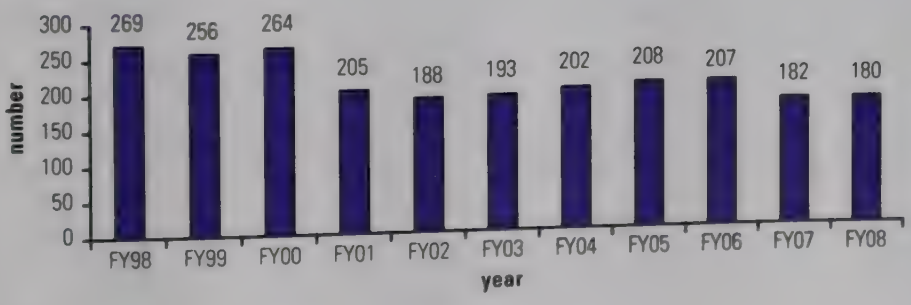
CHAPTER 3

Lending and Staffing Outlook

HNP sectoral lending for FY09 is expected to reach US$3.1 billion, over triple the size of last year's US$948 million. This is the biggest new commitment for a single year in the Bank's history of HNP lending. A large increase in HNP commitments is expected in all Regions, but notably in AFR, SAR, ECA, and LCR. As in previous years, the bulk of financing comprises investment lending. About 23 Poverty Reduction Strategy Credit (PRSC) operations are expected to go to the Board in FY09, half of which include a focus on health (see annex 3). All new investment lending is subject to the rigorous quality enhancement measures discussed in the section on *Enhancing Portfolio Quality*.

Staff levels have remained relatively constant in the last two years (figure 5). The skill mix has remained stable with 20 percent of HNP staff classified as economists in FY09.[14] AFR experienced a drop in staff numbers,

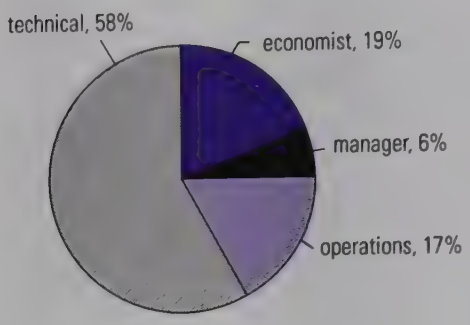
Figure 5: HNP Staffing Trends, FY98–FY08



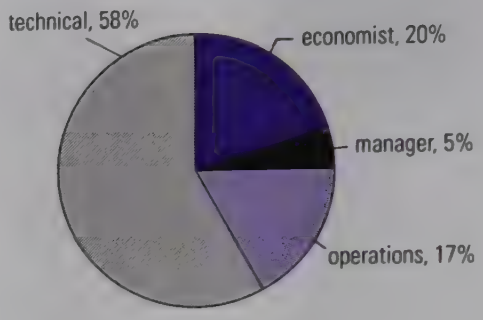
Source: Human Resources, World Bank

Figure 6: HNP Staff Composition, FY07 and FY09

(a) HNP Staff Composition by Specialty—FY07



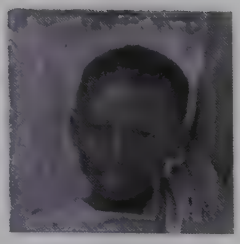
(b) HNP Staff Composition by Specialty



Source: Human Resources, World Bank.

from 51 in FY07 to 47 in FY09. The proportion of economists mapped to HNP in AFR also fell, from 12 percent in FY07 to 9 percent in FY09. A similar trend has been observed in ECA, with staff numbers declining from 22 in FY07 to 17 in FY09.

The Health Systems Strengthening for the Health MDGs program is addressing these trends through hiring of 10 health systems specialists, particularly economists. Of these 10 new hires, 4 staff members will be based in Nairobi, in Dakar, and 2 at headquarters. This program will change both the skill mix and the overall staffing numbers in AFR. In addition, staff will be deployed to critical IHP+ countries (for example, Ethiopia and Mozambique).



CHAPTER 4

Conclusions and the Way Forward

This report notes the progress which has been made since the Strategy was discussed by the Executive Directors in May 2007, including the launch of the new Results-Based Financing program, strengthening monitoring and evaluation activities and improving results frameworks in new Bank operations, implementing the Portfolio Improvement Action Plan and enhancing the sector's pro-poor focus. Health Systems Strengthening is now a key focus of most new HNP operations. High-quality analytical work is contributing to the country and global dialog on health policy and we are taking steps to increase the focus on knowledge creation and dissemination, including the recent formation of the Global Expert Team on HSS. We have scaled up strategic participation in global and regional partnerships to improve the effectiveness of global development assistance for health. Two regional HSS hubs will soon be functioning to enhance our dialog and impact in Africa. The Bank is increasingly engaged in a variety of innovative financing efforts.

The global financial crisis is likely to adversely impact HNP outcomes. The full extent will become clearer in the months ahead and may require adjustments to the Strategy.

As noted in this progress report, much remains to be done during the next phase of the Strategy implementation. In particular, the HNP SB will focus on four key areas (see annex 1 for further details):

- Portfolio performance, including monitoring and evaluation, particularly in AFR, with the expectation that the 75 percent target for satisfactory project exits will be met by the end of FY10.

- Quantity and quality of staff and skill mix. The HNP SB will closely monitor staffing levels with the objective of reaching a balance between economists and health specialists by FY12.
- Multisectorality of HNP interventions. We will start work on developing and implementing the multisectoral constraints assessment tool in FY10.
- Population and reproductive health. Following the completion of the work of the Taskforce on Innovative Financing, which is due to report to the UN General Assembly in September 2009, we will report back to the Board with a detailed plan of action.

ANNEX 1

Action Plan

Table 1: Five-Year Action Plan: Renewing Focus on Results

WHAT?	BASELINE	HOW MUCH AND BY WHEN?	BY WHOM?	FY09 Q3 STATUS
Build statistical capacity for client countries on priority HNP outcome indicators (disaggregated by gender and age) directly through Bank operations and/or supporting global partner's country support (e.g., MDGs). This includes the development of country-based frameworks for the collection of essential household HNP and multisectoral indicators.	Less than 10% of Country Assistance Strategies (CASs) targeting HNP results.	At least 40% of new CASs targeting HNP results to be discussed with the Board in FY09 and thereafter will identify capacity-and-systems building activities (Bank and/or coordinated with global partners) for, monitoring and evaluating HNP results in government programs.	Regional HNP Sector Manager and HNP country team and Country Directors with technical support from HNP Hub and Development Economics (DEC), as needed.	**Achieved.** 40% of FY09 CASs include HNP results.
*Pilot and evaluate impact of output-based and performance-*based financing for HNP-related projects/programs.	Four active projects in FY06.	By FY10, at least 14 active projects with most loan proceeds allocated on output-based financing. Impact evaluation plans in place for 60% of these projects or more upon approval.	Regional HNP Sector Manager and HNP Sector Board with technical support from HNP Hub, as needed.	**Achieved.** Currently, HNP has 16 active projects which have significant RBF components. In addition, there are nine projects which have substantial discussion of RBF pilots or components but the amount of funding going toward these elements has not been determined at this point. Eight impact evaluations are planned (Afghanistan, Zambia, Rwanda, Benin, DRC, Eritrea, Ghana, Kyrgyz Republic) and a special network of impact evaluation experts has been formed to ensure quality and allow for meta analysis

(Continues on the following page)

Table 1: Five-Year Action Plan: Renewing Focus on Results (continued)

WHAT?	BASELINE	HOW MUCH AND BY WHEN?	BY WHOM?	FY09 Q3 STATUS
Develop Bank Global Results Monitoring Framework for key outcomes, outputs, and system performance indicators to be monitored by the Bank globally. This will include indicators on gender disparities in health.	Presented with this new HNP Strategy.	Strategy for global monitoring arrangement designed (in collaboration with global partners) by end FY08. Implementation launched by end FY09.	HNP Hub with support of HNP Sector Board, DEC, and others.	**Under implementation.** A common results framework has been developed by global health partners in close collaboration with countries through the IHP+ working group on M&E. The framework, which is based on the tenets of the Paris Declaration on Aid Effectiveness, has been used to develop a results framework for maternal, neonatal, and child health for the Catalytic Initiative and to assess the extent to which the Global Fund's five-year evaluation adhered to the principles of country ownership, capacity building, independence, harmonization, and alignment. The common results framework was completed mid-FY08 and has been well received by partners.
Introduce Results Frameworks for all projects targeting HNP outcomes, output, and system performance, including baseline data and output targets.	Less than 25% of active projects with satisfactory Results Frameworks as of FY06.	At least 70% of new projects/programs approved by the Board in FY08 and thereafter.	Regional HNP Sector Manager and country team, with technical support from HNP Hub.	**Achieved.** 68% of the FY08 approved HNP projects (25) have satisfactory Results Frameworks.
Periodic data collection and updates (as appropriate to specific indicators) for at least 70% of the indicators included in project Results Framework and updated periodically in Implementation Status Reports (ISRs).	Less than 15% of active projects as of FY06.	At least 65% (annually) of all projects/programs approved by the Board in FY08 and thereafter.	Regional HNP Sector Manager and country team, with technical support from HNP Hub.	**Under implementation.** This work is in progress. A system is being set up to extract relevant information from ISRs, but programmatic limitations exist and completion has been delayed. It is expected that this will be completed by end FY09.

(*Continues on the following page*)

Table 1: Five-Year Action Plan: Renewing Focus on Results (continued)

WHAT?	BASELINE	HOW MUCH AND BY WHEN?	BY WHOM?	FY09 Q3 STATUS
Develop indicators (including gender- based indicators) for priority HNP outcomes for which no agreed indicators exist (e.g. financial protection, governance in the health sector, and financial and fiscal sustainability).	Does not exist.	Develop indicators by end FY08.	*Identification of indicator needed:* HNP country team and Regional HNP Sector Manager. *Development:* HNP Hub in collaboration with PREM, DEC, and country teams.	**Achieved.** Indicators for governance and other health systems building blocks have been developed in collaboration with an intraagency group (end FY08). The so-called health systems indicators toolkit is widely available. The Bank contributed governance indicators and participated in discussions on indicators of financial protection.
Improve results in existing portfolio. Review and restructure existing HNP portfolio (Project Design and/or Project Development Objective, PDO) to achieve satisfactory PDO or higher outcome at project closing.	Annual average of 66% of projects closing with satisfactory PDO or higher result (FY05 and FY06).	75% for FY09 and thereafter (each Region and total HNP portfolio).	Regional HNP Sector Manager with support from HNP Sector Board HNP Hub, IEG, DEC and OPCS.	**Not yet achieved.** 52% of HNP projects that exited and were evaluated by IEG between mid FY07—mid FY09 receiving a satisfactory rating. ECA is at 75% satisfactory—ECA reviewed all HNP projects and addressed fundamental weaknesses that were noted in the design and/or implementation projects. SAR, LCR and EAP are at 71.4%. Africa is at 24% satisfactory rating. MNA is at 0%—MNA had only one exit during this period and this project was rated unsatisfactory.
Concurrent monitoring of overall active Bank portfolio performance and PDO indicators on HNP results. Develop and implement central database with HNP project results based on ISR and project Results Framework data online for monitoring portfolio results and quality.	Does not exist.	Develop by end FY08; implement by end FY09.	*Develop:* HNP Hub in collaboration with results team in OPCS/DEC and with ISG. *Implement:* HNP Sector Board. *Manage:* HNP Hub and HNP Sector Board.	**Under implementation.**

Table 2: Five-Year Action Plan:Strengthening Health Systems and Ensuring Synergy between Health System Strengthening and Priority-Disease Interventions

WHAT?	BASELINE	HOW MUCH AND BY WHEN?	BY WHOM?	FY09 Q3 STATUS
Increase support to Bank country teams to *identify health system constraints (including gender-specific constraints) to achieving HNP results* and mainstream system-strengthening actions to overcome constraints in all new HNP operations (or other sectoral or global partner operations), including priority-disease interventions.	Less than 25% identify health system constraints. Less than 45% include health systems strengthening in areas of Bank comparative advantages.	Develop operations toolkit for rapid assessment of health system constraints for better outcomes (completed by end FY08). Complete identification of 7 countries by December 2007. Launch on-demand support in four countries by June 2008. Put on-demand support in place to Bank country teams in 7 countries by June 2009. At least 60% of projects approved in FY09 and thereafter will include assessment of health systems constraints to reaching HNP results. At least 70% of those identifying constraints will include appropriate policy actions/investments to overcome them.	*Identify countries:* Regional HNP Sector Managers with support from HNP Hub. *Provide support to country teams:* Health System Policy Team (HSPT) (see below). *Support client countries in designing system-strengthening interventions:* Country teams with on-demand support from HSPT. *Support country teams in assessing health system constraints:* HNP Hub.	**Under implementation.** First phase of support to 14 IHP+ countries in progress. See progress under #11 below.

(*Continues on the following page*)

Table 2: Five-Year Action Plan:Strengthening Health Systems and Ensuring Synergy between Health System Strengthening and Priority-Disease Interventions (continued)

WHAT?	BASELINE	HOW MUCH AND BY WHEN?	BY WHOM?	FY09 Q3 STATUS
Assemble Health Systems Policy Team (HSPT) and hire additional health system staff for the Regions (contingent on budget availability).	Does not exist.	Write TORs and launch recruitment process by December 2007. Complete recruitment by June 2008. Put team in place and working by December 2008.	HNP Hub in coordination with HD Council and HNP Sector Board. Team would be located in restructured HNP Hub. Regional Staff in Regions.	**Under implementation.** A new Health Systems for the Health MDGs program was launched in 2008. The Bank is locating senior staff skilled in health systems strengthening implementation in Ethiopia, Mali, Mozambique, and Nepal in calendar year 2009, and in other IHP+ countries (Benin, Burundi, Cambodia, Ghana, Kenya, Madagascar, Nigeria, Rwanda, and Zambia) through 2011. The recruitment process for 15 staff members (10 funded by the Bank's budget, 5 from external resources) is ongoing and set to be complete by the end of FY09 Q3. Two regional hubs staffed by local and international experts have now been established in Nairobi and Dakar.
Put in place arrangements for collaborative division of labor on health systems with global partners at global and country levels.	Does not exist.	Dialog in place for global arrangements by December 2007. Launch collaborative division of labor arrangements for at least 10 countries where projects/programs include interventions requiring expertise other than Bank comparative advantages (by December 2008).	*Global arrangements:* HNP Network Director with support from HD Vice President, HD Council, HNP Sector Board, and HSPT. *Country-level arrangements:* Country teams with support of Regional Sector Manager and HSPT.	**Achieved.** IHP+ was launched in September 2007. Thirty-five partners have joined IHP+. Three IHP+ compacts have been signed, in Ethiopia, Mozambique, and Nepal. Additional compacts likely to be signed in FY09 include Zambia, Mali, Madagascar, and Cambodia. The Bank has developed and implemented a collaborative work program with WHO, resulting in joint leadership in and management of IHP+ and the High Level Taskforce on Innovative International Financing for Health Systems

(*Continues on the following page*)

Table 2: Five-Year Action Plan:Strengthening Health Systems and Ensuring Synergy between Health System Strengthening and Priority-Disease Interventions (continued)

WHAT?	BASELINE	HOW MUCH AND BY WHEN?	BY WHOM?	FY09 Q3 STATUS
				The Bank participates in the informal group of leaders of eight global international health agencies (H8), who agreed to meet regularly to strengthen linkages and work jointly to discuss challenges to scaling up health services and improving health-related MDG outcomes. The Bank is discussing arrangements for collaboration with Global Fund and GAVI.
Focus knowledge creation and policy advice (AAA) on Bank comparative advantages. Increase proportion of country- and regional-level AAA, appropriate to requirements of LICs and MICs, focused on Bank comparative advantages.	Less than 35% so focused.	By end FY08, 50% and by end FY09 70% of new HNP sector AAA will be focused on areas of Bank comparative advantage in specific areas appropriate for LICs' and/or MICs' requirements (e.g., health system financing, demand-side determinants of results, intersectoral contribution to HNP results, private-public collaboration).	Regional HNP Sector Manager with support from HSPT.	**To be implemented.** This has proved difficult to assess, as project classification is subjective. As such, based on TTL-classification of HNP AAA in FY08 and FY09, little progress has been made, with only 12% of AAA in FY08 and 33% in FY09 falling under the areas of Bank comparative advantage according to OPCS coding (BK, FB). Based on an initial content analysis of these same programs, however, different estimates have been reached, with AAA in FY08 and FY09 falling into areas of Bank comparative advantage at rates of 46% and 45%, respectively. Further work needs to be done to clarify coding and classification. Despite this, however, progress is slow in shifting to areas defined as "comparative advantages" of the Bank.
Develop and implement a training and accreditation program for Bank staff on *technical and operational aspects of health system strengthening.*	Does not exist.	In place by end FY08; 30% of HNP staff accredited by end FY09; 60% of HNP staff accredited by end FY10.	HNP Sector Board with support from HNP Hub, WBI, and DEC.	To be implemented. An 8-module (2.5 day) course on SWAps has been developed.

Table 3: Five-Year Action Plan: Strengthening Bank Intersectional Advisory Capacity

WHAT?	BASELINE	HOW MUCH AND BY WHEN?	BY WHOM?	FY09 Q3 STATUS
Develop, pilot test, and implement Multisectoral Constraints Assessment (MCA) tool and process. Pilot test in a number of LICs and MICs.	Does not exist.	First tool will be developed by end FY08 and pilot tested in 2 MICs and 2 LICs by end FY09.	*Development:* Intersectoral thematic group (all sectors concerned through respective Hub Sector Managers, led by HNP Hub Sector Manager). Ad hoc technical team to design instrument. *Selection of country pilots:* Virtual intersectoral thematic group and Country Directors. *Implementation of pilots:* Ad-Hoc TTL from country team and Regional Sector Manager, under oversight of intersectoral thematic group.	**To be implemented.**
Identify lending and AAA in CAS. MCA-identified HNP-related Bank proects/programs/components in CAS.	Does not exist.	MCA will be used to identify 40% of projects/programs with HNP results included in at least 50% of new CASs discussed with Board by FY10 and thereafter.	Regional HNP and other Sector Managers involved with support from HNP Hub and intersectoral thematic group.	**To be implemented.**
Develop, implement, and manage an intersectoral coordination thematic group for HNP results.	Does not exist.	Functioning by December 2007.	The thematic group would be composed of interested sectors through their respective sector Hub Managers. *Development:* HNP and other sector Hub Managers. *Management:* HNP Hub Director.	**Achieved.** Intersectoral coordination thematic group launched.

Table 4: Five-Year Action Plan: Increasing Selectivity, Strategic Engagement, and Collaborative Division of Labor

WHAT?	BASELINE	HOW MUCH AND BY WHEN?	BY WHOM?	FY09 Q3 STATUS
Increase use of harmonization and alignment principles for Bank projects at country level.		By FY11, at least 81% of projects approved by Board will be based on country fiduciary systems or will have common fiduciary arrangements/rules for all participating donors.	Country teams with support of Regional Sector Manager, Regional Fiduciary Teams, and on-demand support from HSPT.	**Under implementation.** The Bank is in the process of aligning activities with the government and other key stakeholders in IHP+ countries to varying degrees. The Bank is harmonizing procurement with UN agencies, based on a template agreement which is now in place with UNICEF (and in progress with UNFPA). The Bank is pursuing a second phase for a joint Bank-WHO work program on strengthening health systems.
Develop overall HNP Fiscal Space assessment in priority countries.	Does not exist.	Develop and pilot Fiscal Space assessment methodology (completed by end FY08). Full Fiscal Space assessment in 7 priority countries in coordination with Global Partners.	HNP Hub in collaboration with DEC and PREM and with Regional HD Departments. Country teams with support from HNP Hub.	**Under implementation.** Guidelines are in development, to be completed by the close of FY09. Fiscal space assessments have been completed for the following priority countries: Uganda, Rwanda, Ukraine, India, and Indonesia.
Review and reorient Bank grants (DGF) in HNP toward areas of Bank comparative advantages.	Currently less than 1% of DGF grant financing is allocated to partners working on issues related to Bank comparative advantages.	By end FY08, 5%, by end FY09, 30% and 50% by end FY10 of DGF grant financing will be allocated in partnerships related to Bank comparative advantages.	HNP Sector Board with support of HNP Hub.	**To be implemented.** Restructuring of DGF HNP program is still to be undertaken.
Realign secondments and Trust Fund management in HNP sector with Bank comparative advantages.	Currently 60% of secondments in HNP sector are in areas in which Bank has little comparative advantage.	By end FY09, 80% of secondments to Bank and 80% of total Trust Fund financing managed by HNP sector will be in areas of Bank comparative advantages.		**Under implementation.** As of FY08, secondments are equally split among the areas of health systems strengthening (50%) and priority disease and other public health areas (50%).

ANNEX 2

More on the HNP Portfolio

Portfolio Status

The HNP portfolio has grown from US$7.7 billion in mid-FY07 to US$8.2 billion in February 09. In terms of the number of projects, Africa continues to have the most (35 percent), followed by LCR (20 percent) and ECA (15 percent). At the time of the adoption of the new Strategy in 2007, net commitments were highest in the Africa and LCR Regions. However, South Asia's commitment size increased by about 50 percent since mid-FY07 and the region currently has the largest share (29 percent) in the HNP portfolio. Africa has the second largest share at 26 percent (Figure A1).

In terms of thematic focus of the HNP portfolio, projects with a primary focus on HSS have increased from 50 percent to 52 percent since FY07,

Figure A1: Share of HNP Portfolio Net Commitments by Region

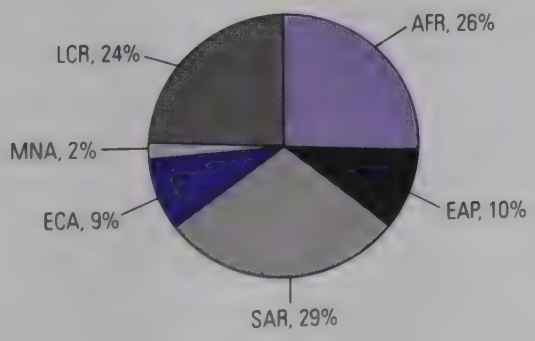
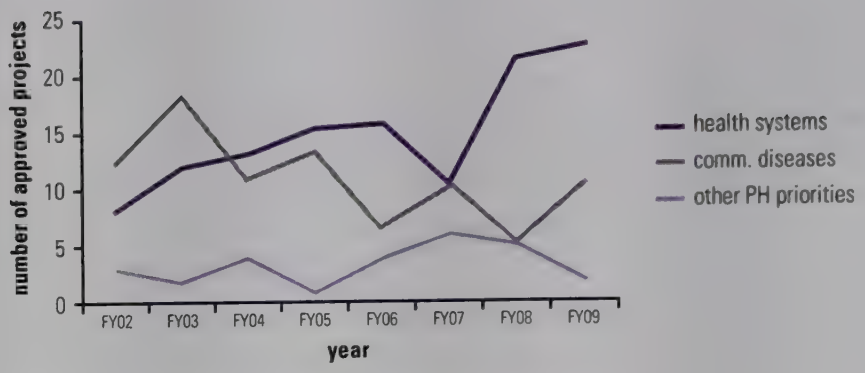


Figure A2: Types of HNP SB Projects Approved, FY02–09



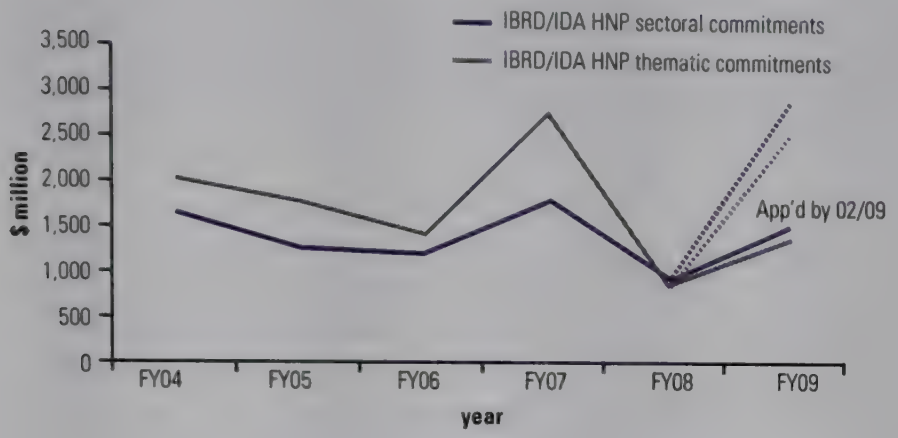
Note: Data as of 01/31/09. Includes IBRD/IDA, SF and RE ($5m+) operations.

while projects with a primary focus on communicable diseases have fallen from 41 percent to 37 percent.[35] This is line with the Strategy's emphasis on HSS. Moreover, new projects which primarily focus on health systems have increased significantly and over half of new projects that focus on HIV/AIDS and other communicable diseases explicitly address HSS issues.

New Lending for HNP

New lending has also shown an increase from US$1.26 billion in FY06 to a projected US$3.2 billion for FY09, of which US$1.6 billion is already approved. The large increase is due to the postponement of several large projects that were originally scheduled to go to the Board in FY08. Other sectors are expected to contribute to about half of HNP commitments, which is keeping with one of the Strategy's objectives of addressing health outcomes through multisectoral interventions. Even though in percentage terms it is comparable to previous years, the actual amount being managed by other sectors (US$1.6 billion) is expected to triple the previous five-year average of US$500 million. Similar to last year, the Africa Region will have a large share (US$790 million), but due to several large operations, LCR is projected to have the largest share of HNP commitments in FY09 (US$860 million). For both the LCR and ECA regions, non-HNP sector boards are projected to manage US$500 million of HNP sectoral lending. As for HNP thematic lending, health system performance has the largest share, as in previous years (US$1 billion, or 36 percent of all HNP thematic lending).

Figure A3: HNP IBRD/IDA New Commitments, FY04–FY-09



Of the projected US$3.2 billion for FY09, slightly over half (US$1.7 billion) is IBRD lending, predominantly managed by other sectors. However, the HNP Sector Board's commitments are largely IDA (64 percent or US$1 billion) as health operations are concentrated in lower-income countries.

Portfolio Quality

As of end February 2009, 26.2 percent (or 38 out of 145) of active HNP projects were at-risk, which is significantly higher than the Bank's average of 21.2 percent. The percentage of at-risk projects has been increasing since mid-FY07, when less than 15 percent of HNP projects were at-risk. There is a significant variation in riskiness across regions. As the table below shows, the AFR has the highest percentage of projects at-risk, while the riskiness in other Regions is approaching regional averages for other sectors, though there is scope for improvement, particularly in MNA and EAP. Also, projects with a significant component on HIV/AIDS seem to be of higher risk compared to other HNP projects in all Regions except EAP. Looking at the risk flags, many projects in Africa, especially those with a significant HIV/AIDS component, seem to be facing problems in the areas of project and financial management and tend to be at-risk for a long time (as shown by the long-term flag). Thus compared to projects in other sectors in AFR, the HNP sector seems to suffer from lower institutional capacity at the country level. In addition, it appears that remedial actions to address problems in the projects need to be more timely and effective.

Figure A4: Percentage At-Risk for HNP Projects and Projects with a Significant AIDS Component

		% PROJECTS AT-RISK				
REGION	# OF HNP PROJECTS (OF WHICH AIDS)	PROJECTS AT-RISK IN ALL SECTORS	ALL PROJECTS MINUS HNP	HNP PROJECTS AT-RISK	HNP MINUS HIV/AIDS	HIV/AIDS
AFR	51 (24)	26.1%	24.9%	35.3%	29.6%	41.7%
EAP	21 (1)	14.3%	13.5%	23.8%	25.0%	0%
SAR	15 (4)	21.1%	21.2%	20.0%	18.2%	25.0%
ECA	22 (3)	18.4%	18.4%	18.2%	10.5%	66.7%
MNA	7 (0)	27.5%	27.4%	28.6%	28.6%	
LCR	29 (10)	20.7%	20.7%	20.7%	15.8%	30.0%
Total	145 (42)	21.3%	20.8%	26.2%	21.4%	38.1%

Data as of February 26, 2009.

As noted in the main text, IEG outcome ratings for HNP projects evaluated between mid-FY07 to date were far below the Bank-wide average, and HNP's net disconnect is the highest among all sectors. While in all Regions the percentage of projects with satisfactory outcomes was below regional average, EAP, ECA, and LCR Regions are approaching the target. Similar to data on riskiness, the Africa Region and projects with significant HIV/AIDS components have low percentages for satisfactory outcomes, as well as a high net disconnect. Other reviews such as the QAG review of at-risk projects, FY08 annual review of project performance, and the IEG review of Bank's support in HNP, identified areas of special concern for HNP projects in all Regions, namely: strengthening sector management oversight; reviewing current resources for preparation/supervision; declining attention to family planning and nutrition; and addressing two key weaknesses: monitoring and evaluation as well as institutional analysis.

Portfolio Improvement—A High Priority

The HNP Sector Board is working collectively to enhance the oversight of the portfolio and ensure that continuous efforts are made to improve the performance of HNP projects. A detailed Portfolio Improvement Action Plan that includes all at-risk projects, as well as those needing additional management oversight to avoid falling into at-risk status, has been developed and is being monitored on a quarterly basis by the HNP Sector Board.

This Action Plan addresses some of the key concerns raised by the various reviews and involves a thorough risk analysis of each region's portfolio to both introduce risk mitigation measures, as well as identify those projects that are not currently at-risk but need more attention to improve their performance. Quarterly updates on the status of the HNP portfolio are distributed to the HD Council, and monthly updates are given to all HNP sector managers, which enable them to have a global view of the HNP portfolio and enhance cross-regional support. Moreover, the HNP Sector Board is making a special effort to ensure that quality enhancement inputs from QERs, Peer Reviewers, and the like, are properly reflected in the design and implementation of projects under preparation.

At the Regional level, various efforts are underway. For example, the Africa Region has implemented several changes aimed at improving its HNP portfolio (see box 2 earlier in the document). Africa is also receiving additional technical and financial support through the "Health Systems for Health" MDGs program, which will address the weaknesses identified in the various reviews. Follow-up actions in the two most recent ISR reports are closely monitored, and early restructuring to revise ill-defined PDOs is strongly encouraged. A comprehensive approach has also been adopted to improve the quality of HIV/AIDS projects, including an umbrella restructuring package of 11 MAP projects in FY07. Moreover, additional technical support is provided to improve implementation, develop impact evaluation capacity, as well as strengthen governance and accountability within national HIV/AIDS programs. In EAP, a thorough portfolio review has resulted in the use of restructuring of poorly performing projects to improve portfolio quality. In addition, a project that has shown improvements in performance is being upgraded. These measures are expected to reduce riskiness dramatically. In FY07, ECA made a concerted effort to improve portfolio performance in the HD sector; this included receiving VPU contingency funds to also strengthen Results Frameworks. These efforts yielded impressive results in HNP, where the riskiness dropped from 30 percent in mid FY07 to the current 18 percent. This has reduced ECA's percentage of projects at-risk below the Bank and Regional averages as of end February 2009.

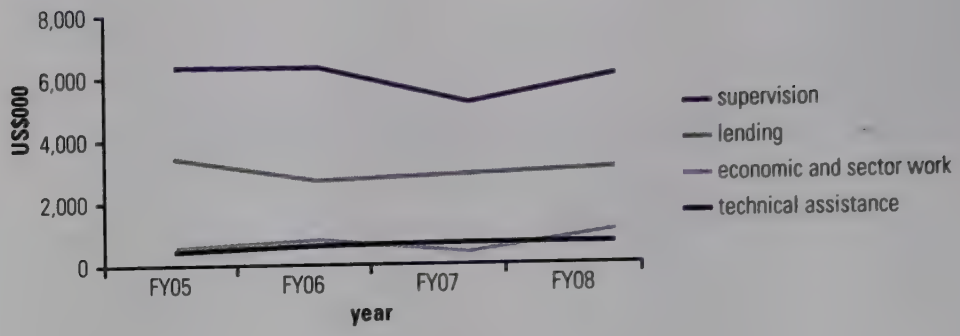
ANNEX 3

Bank Supervision Budgets by Region

Trends in Supervision Budgets for Bank Health Projects by Region

- **Africa**—Supervision and lending budgets for the Africa region decreased between FY05 and FY08. In order to ensure full use of IDA14 allocations, there was a slight increase in lending preparation in the latter half of FY07.
- **East Asia and the Pacific**—Total supervision budgets in EAP showed a sharp decline from FY04 to FY05/06, but have nearly recovered to FY04 levels by FY08. The proportion of supervision financed by trust funds has increased in recent years. In some CMUs, the availability of trust funds for supervision clearly supplements Bank resources.
- **Middle East and North Africa**—Overall budget for supervision in MNA has remained relatively constant. More than other regions, however, MNA has a number of projects with large budgets for supervision (for example, Iraq, Iran) due to the intense supervision required and the high cost for security. Limited funds have been available for restructuring of problem projects, with MNA having leveraged additional funds for supervision; however such resources are necessary over the long term in order to have a substantive impact on project outcomes.
- **Latin America and the Caribbean**—On average, supervision budgets have remained roughly constant in nominal terms for the past four years. Problem projects have received supplemental funding.

Figure A5: Africa Region Spending Trends in HNP36



- **Europe and Central Asia**—A review of ECA supervision budgets since FY06 shows fluctuations, particularly at the project level. While some of the more challenging projects have received additional funds for supervision, the general trend implies that supervision budgets are linked to previous year expenditures.
- **South Asia**—Supervision budgets for South Asia increased from FY07 to FY08, with actual spending outpacing planned disbursement. Only partway through FY09, the region is on track to meet planned disbursements for supervision.

ANNEX 4

More on Health Systems Strengthening

Selected Success Stories from Health Systems Strengthening

- **Argentina's** *Plan Nacer* has been an effective results-based financing program aimed at improving the coverage of a defined package of maternal and child health interventions, targeting uninsured mothers and children.
- **Rwanda's** health reforms have linked financing to health service delivery, increased provision of health insurance for the poor, and transformed health organizations to make them more accountable for results.
- **India's** Tuberculosis Control Project, whereby directly observed treatment, short-course (DOTS) was extended to most of the country as a result of IDA-supported capacity development of state- and local-level public health agencies.
- **The Arab Republic of Egypt's** Health Sector Reform Project helped to reduce the financial burden for the poor and uninsured of primary health care through a focus on a Family Health Model.
- **Afghanistan's** Afghanistan's Health Sector Emergency Reconstruction and Development Project, whereby the government, with IDA support, contracts NGOs to provide health services to approximately six million rural people.

Examples of Recently Approved Health Systems Strengthening Programs

- In **Cambodia,** a recently approved US$30 million program intends to improve health outcomes through strengthening institutional capacity and mechanisms through which the government and development partners can achieve more effective and efficient health sector performance.
- Overall **HNP programmatic interventions in Madagascar** have supported an increase in the Ministry of Health's budget execution rate from 65 percent in 2007 to over 80 percent in 2008. Most recently, a newly created health Sectorwide Approach (SWAp) has been introduced with joint buy-in from the government and development partners, and financial support in the form of the first pooled financing operation by IDA and the French Agency for Development.
- The US$16 million **Congo** Health Services Development Project will support the strengthening of health systems to effectively combat the major communicable diseases and improve access to quality services for women, children, and other vulnerable groups.
- In **Kazakhstan,** the US$78.9 million health sector reform project is working to introduce international standards and build long-term institutional capacity in the Ministry of Health and other institutions involved in health service delivery to support key health sector reform objectives identified by the government.

More Detailed Health Systems Strengthening Experience

- The **Ethiopia Protection of Basic Services Sectoral Investment Loan** (PBS SIL) is a successful example of a multisectoral health and education project that relies on performance-based outcomes for provision of basic services in both sectors. The program has trained 24,000 health extension workers, through targeting of females in tenth grade.
- Since 2004, the World Bank has been engaged in the **Health Reform Implementation Project in the Chuvash Republic in Russia.** The focus of this project has been to assist in the refocusing of public health

spending from hospital and tertiary care to the development of primary health care. The project has successfully increased total public health spending on primary care from 30.6 percent in 2003 to 42.2 percent in 2007, created general practice units that provide care for families and individuals at the community level, and implemented more flexible governance arrangements to recruit and retain general practitioners.

- The **Kyrgyz Health Sector Reform II Project** used strong macro-sectoral dialogue and collaboration with government and other partners to pave the way for a SWAp through a project that improved oversight and coherence of health financing and implementation, and led to expansion of coverage of a primary health care package to 90 percent of the population, improvements in health service quality and equity, and reductions in informal payments.

- Building on the success of Phase I, Phase II of the **Turkey Health Transformation and Social Security Reform Project** is continuing to support the national strategic health plan; implementing reforms in provider payments and health systems performance; and carrying out pilots of output-based financing for preventive health services. Most notable is the ongoing piloting of output-based financing mechanisms for preventive health care services at the provincial level, which finances per-capita payments to family medicine practices for preventive health care interventions for the control of noncommunicable diseases.

- In **Timor-Leste, the First and Second Health Sector Rehabilitation and Development Projects** (HSRDP1 and HSRDP2) supported reconstruction and strengthening of the health sector following the 1999 referendum on independence, in which nearly 80 percent of health facilities were destroyed. The HSRDP projects provided a coordinated framework for donor support to the sector (through a multidonor trust fund arrangement), and contributed to reconstruction and equipping of health clinics and regional hospitals, training of health managers and staff, strengthening the health management information system, and improved planning and implementation at the district level. The Bank led semiannual Joint Donor Reviews of progress in the sector in the context of a sector-wide approach. Despite periodic unrest and implementation challenges in a post-conflict context, the project contributed to significant improvements in coverage and utilization of health services. From 2001 to 2007, for

example, child vaccination coverage (DPT3) improved from 25 percent to 75 percent (based on the Timor-Leste Standards of Living Surveys). While these sector improvements cannot be attributed only to the projects, they clearly contributed.

- The US$50 million loan and DFID Trust Fund and Bilateral Grant of £5 million for the **China Rural Health Project** (2009–2013) supports innovations and generates knowledge useful to the government for its ongoing health reform program. The project gives approximately US$1 million grants to each of 40 project counties in 8 provinces for health reform along 3 dimensions: (a) health financing; (b) health delivery; and (c) public health. The project rewards successes with incentive funding and asks poor performers to stop and return funds. In the first 6 months of the project, the Bank has received about 30 proposals for reform projects. Central-level authorities are looking for rigorous monitoring and evaluation during this time of health reform in China.

- The **Arab Republic of Egypt's Health Sector Reform Project** has shown success in expanding access to, and coverage of, a basic benefits package of primary health services. Despite improvements in quality of care, the project had faced difficulties expanding coverage among the poor and uninsured due to required registration fees for access to the basic benefits package. In response to this challenge, the Bank supported government efforts to increase financial support to the poor and develop appropriately targeted exemption of registration fees and health services co-payments for the poor using proxy-means testing developed by the Ministry of Social Solidarity.

- The **Yemen Queen of Sheba Safe Motherhood Project** provides essential quality services (antenatal care, natal, postnatal care services, and family planning education) to eligible poor women of reproductive age (15–49 yrs) living in the urban slum district of Sana'a (with scale-up in subsequent fiscal years). This project proposes to increase utilization of these services and birth assistance by skilled birth attendants through output-based disbursements delivered through a private hospital (supply side intervention) and a non-governmental organization (NGO) (outreach/demand-side intervention). The project funds service delivery, 50 percent of the capital costs for establishing satellite clinics education and awareness campaigns, and community outreach programs.

ANNEX 5

Population and Reproductive Health

Innovations and Successful Interventions: Pop/RH at the Bank

One of the ways that the Bank has contributed to achieving MDG 5 in its client countries is through identifying and scaling up innovative approaches to Pop/RH. This includes both technical and financial innovation. For instance, to promote efficient use of health funding, the Bank has employed RBF mechanisms in several countries. With support from a multidonor trust fund, these finances are earmarked for strengthening health systems as well as increasing focus on maternal, neonatal, and child health services. Round I of the funding is supporting seven countries, six of which are in Africa: Eritrea, Rwanda, Zambia, Ghana, Benin, Ethiopia, Madagascar, and Afghanistan. In addition, DRC is receiving seed funding for a study.

The Bank has supported several successful and innovative programs in LCR. In Argentina, the **National Sexual and Reproductive Health Program** increased health coverage for women of child-bearing age through its support for **Plan Nacer,** which has led to a decline in MMR from 47 in 1997 to about 40 in 2004. In Honduras, the Bank supported 11 community managed models for provision of health services to the rural poor. It is estimated that the project may be responsible for reducing MMR by half. In the MNA region, innovative methods have been successfully employed to lower fertility rates in Egypt. The **Population and Health Project** was successful in raising the demand for family planning services in Upper Egypt (which generally has a higher TFR as compared to the national average of three). This was accomplished by incorporating culturally sensitive women's

empowerment programs and the use of community-based workers. The Bank has also recently committed US$6.5 million to another innovative project: the **Safe Motherhood Voucher Project** in Yemen.

In Africa, the **Population and AIDS Control Project** in Chad is innovative in that it has combined efforts to control and reverse the spread of HIV/AIDS with efforts aimed at improving information on birth spacing and access to modem contraception. At the programmatic levels, the project has built on the commonalties to be found between HIV/AIDS and population interventions in order to capitalize on their synergies. These common efforts encompass: information, education, and communication programs and behavior change communication that are aimed both at reproductive health and HIV/AIDS prevention; interventions targeted at vulnerable groups (for example, women, youth, commercial sex workers); treatment of sexually transmitted infections (STIs); and promotion of condoms. The project succeeded in helping advance the onset of fertility decline by increasing the knowledge and the use of modern contraceptive methods, and by slowing the spread of HIV/AIDS infection by promoting greater awareness and behavioral change.

The **Population and Family Planning Project** (a Learning & Innovation Credit) in Malawi is a targeted approach to Pop/RH activities. This project was designed with the objective of testing the implementation of a comprehensive community-based distribution (CBD) program for the delivery of population and family planning services. The project proved the hypothesis that district-wide implementation of CBD activities could be done successfully. The end-project survey showed that 95 percent of the adult population in control districts held a positive view of family planning (FP). Contraceptive use also doubled in all villages covered in the pilot districts while the contraceptive prevalence rate rose from about 20 percent to 36 percent. The project recruited and trained almost twice as many community-based distribution agents as originally planned, while maintaining a very low rate of attrition.

The main objective of the **Health Sector Development Program in Ethiopia,** a SWAP-based operation, was to develop a health system which provides comprehensive and integrated primary care services, primarily based at community health level facilities. RH activities, including traditional maternal health as well as FP services, were part of the project's health service delivery component, which successfully ensured access to basic primary health care services, including a comprehensive maternal child health

package. The focus was on communicable diseases, common nutritional disorders, environmental health and hygiene, reproductive health care, immunization, the treatment and control of basic infectious and epidemic diseases like malaria, and the control of sexually transmitted diseases, especially HIV/AIDS.

The **HIV/AIDS/STI, TB, Malaria and Reproductive Health Project** (HAMSET II) in Eritrea is also an example of innovative projects supported by the Bank. This project tries to exploit the synergies between reproductive health and HAMSET diseases. The project consists of a multisectoral response which supports non-health line ministries and civil society organizations to scale up prevention (especially behavior change communication and stigma reduction), care and support interventions for HIV/AIDS/STI, malaria, TB and RH (with emphasis on mobilizing communities to utilize health services), and a health sector response which includes HIV/AIDS/STI, TB, malaria, RH, and Human Resources for Health. The project's development objectives are to: (a) contain the spread of HIV/AIDS/STI in vulnerable groups as well as the general population through a focused multisectoral approach; (b) expand the coverage of DOTS, and improve case detection and treatment outcomes for TB; (c) reduce or at least maintain malaria mortality and morbidity at currently low levels; (d) improve the coverage of effective RH interventions; and (e) strengthen the overall health system, including human resources for health, to enable the country to better address HAMSET diseases.

In South Asia, the Bank has just held a regional consultation around the launch of the Bank publication, **Sparing Lives: Better Reproductive Health for Poor Women in South Asia,** which summarizes extensive analytical work on reproductive health. In the **India Second Reproductive and Child Health Project** (RCH2), the Bank has pooled funds with DfID and UNFPA, totaling US$830 million. The project aims to expand the use of essential reproductive and child health services of adequate quality with reduction of geographical disparities. The main pillars of the program are: (a) implementation of evidence-based technical strategies for RCH; (b) focus on vulnerable groups; (c) decentralized planning and management; and (d) strengthening of program management systems. The program includes demand-side interventions and supply-side interventions to improve access to and quality of RCH services, especially to the poor. The **Tamil Nadu Health System Project** has established Comprehensive Emergency Obstetric and Newborn Care Centers.

The **Bangladesh Health, Nutrition and Population Sector Program,** a SWAp comprising US$1.3 billion from seven development partners, has supported the provision of Emergency Obstetric Care (EmOC); training of skilled birth attendants; expanded access to and introduction of new methods family planning; and a maternal health voucher scheme, in order to increase poor women's utilization of quality maternal healthcare services. Analytical work by the Bank in Bangladesh has also supported a maternal mortality survey to provide nationally representative maternal mortality ratio estimates and knowledge of determinants of maternal deaths.

Notes

1. The IEG recommendations focus on five broad areas: improving the performance of Bank support for HNP, renewing commitment to improving HNP outcomes among the poor, helping improve the efficiency of country health systems, enhancing support and contribution from other sectors for attaining HNP results, and boosting investments in, and incentives for, evaluation.
2. The 2007 Strategy defines HSS as follows: putting together the right chain of events (financing, regulatory framework for private-public collaboration, governance, insurance, logistics, provider payment and incentive mechanisms, information, well-trained personnel, basic infrastructure, and supplies) to ensure equitable access to effective HNP interventions and a continuum of care to save and improve people's lives. (See page 5 of the 2007 HNP Strategy).
3. As of February 2009, twelve countries (Burundi, Cambodia, Ethiopia, Kenya, Madagascar, Mali, Mozambique, Nepal, Nigeria, Rwanda, Uganda, and Zambia), nine international organizations (WHO, World Bank, Global Fund, GAVI, UNFPA, UNAIDS, UNICEF, UNDP, and EC), eleven bilateral donors (Australia, Finland, Sweden, UK, Norway, Germany, France, Italy, Portugal, Canada, and the Netherlands), and two other donors (Bill & Melinda Gates Foundation, African Development Bank) were signatories of the IHP global compact.
4. The H8 organizations are the Bill & Melinda Gates Foundation, GAVI Alliance, Global Fund, UNAIDS, UNFPA, UNICEF, WHO, and World Bank.
5. World Bank (2009), *The Financial Crisis and Health: Lessons and Recommendations from Previous Experiences.* Web-link: http://siteresources.worldbank.org/INTHSD/Resources/376278-1202320704235/ProtProPoorHealthServFin.doc.
6. Results-based financing is a government tool to disburse funds in cash or in-kind, conditional on measurable actions being taken or conditional on the attainment of a defined performance target. RBF mechanisms can complement broader HSS efforts by focusing more attention on results rather than solely on inputs. RBF programs can work either from the supply side (for example, the paying of bonuses to health facilities that meet certain quantity or quality targets), or the demand side (for example, providing incentives and support to the poor to overcome financial and other barriers to health service utilization).
7. During the 2005 Board discussion of the report from the Committee on Development Effectiveness, "Committing to Results: Improving the Effectiveness of HIV/AIDS Assistance and Draft Management Response," questions and concerns were raised about the IEG's [formerly Operations and Evaluation Department's] evaluation methodology of the Bank's HIV/AIDS assistance. (See, for instance, CODE2005–0075, paragraphs 5 and 14).

8. Net disconnect is the difference between the percentage of projects rated unsatisfactory, that is, unlikely to achieve their development objectives by IEG and the percentage rated unsatisfactory by the Regions in the final Implementation Status and Results Report.
9. Investment Lending Reform—Concept Note (SecM2009–0026), January 29, 2009.
10. Many of these are similar to issues raised by IEG and QAG (in their Quality at Entry, Quality at Supervision and Quality Assessment of the Lending Program reviews).
11. The Portfolio Improvement Action Plan includes an analysis of the critical obstacles to project improvement, changes needed to upgrade projects, and measures to restructure or cancel if needed. Additional financial and/or technical support to achieve these improvements is an explicit part of the plan.
12. A recent example being WHO (2008), *Closing the Gap in a Generation: Report of the Commission on Social Determinants of Health*. Geneva: World Health Organization.
13. P4H is part of IHP+.
14. Wagstaff, A. and E. Van Doorslaer (2003), "Catastrophe and Impoverishment in Paying for Health Care: With Applications to Vietnam 1993–98." *Health Economics*, 12 (11): 921–93.
15. Bredenkamp, C. and M. Gragnolati (2007), "Sustainability of Health care Financing in the Western Balkans: An Overview of Progress and Challenges." *Policy Research Working Paper #4374*, Washington, DC: World Bank.
16. Berman, P., R. Ahuja, and L. Bhandari (2008), "The Impoverishing Effect of Health Care Payments in India: New Methodology and Findings." Unpublished Manuscript, SASHD, World Bank.
17. Lindelow, M. and A. Wagstaff (2005), "Health Shocks in China: Are the Poor and Uninsured Less Protected?" *Policy Research Working Paper #3740*. Washington, DC: World Bank.
18. International Finance Corporation (2008), *The Business of Health in Africa: Partnering with the Private Sector to Improve People's Lives*, Washington, DC.
19. The countries are: Benin, Burundi, Eritrea, Ethiopia, Ghana, Kenya, Madagascar, Mali, Mozambique, Nigeria, Rwanda, and Zambia. The program will also provide support to two Asian countries that are part of IHP+: Cambodia and Nepal.
20. Administrative costs of the program will be covered by an incremental Bank budget of about US$3 million a year. This will be supplemented by about US$3.9 million from development partners.
21. The Harmonization for Health in Africa mechanism brings together the Bank with WHO, UNICEF, UNFPA, UNAIDS, and the African Development Bank.
22. As of March 2009, twelve countries (Burundi, Cambodia, Ethiopia, Kenya, Madagascar, Mali, Mozambique, Nepal, Nigeria, Rwanda, Uganda and Zambia), nine international organizations (EC, GAVI, Global Fund, ILO, WHO, World Bank,

UNAIDS, UNDP, UNICEF, and UNFPA), eleven bilateral donors (Australia, Canada, Italy, Finland, France, Germany, Sweden, Netherlands, Norway, Portugal, UK), two other donors (African Development Bank and the Bill & Melinda Gates Foundation), and one other partnership (Harmonization for Health in Africa), were signatories of the IHP global compact. Letters of support have been received from the OECD and the United States (PEPFAR and USAID) and civil society is engaged fully as a key partner.

23. The country compact is a negotiated and signed time-bound agreement (though not legally binding) in which all partners commit to implement and uphold the defined country health priorities outlined in the validated country health strategy.
24. This work is being conducted in collaboration between HDN and CFP.
25. For meeting report see: http://www.internationalhealthpartnership.net/pdf/IHP%20Update%2013/Taskforce/london%20meeting/new/Taskforce%20NFR%20(short)%20London%20Meeting%20Mar%2013%20final.pdf
26. AMCs address a longstanding development problem of markets with persistent failures to develop and produce products needed in poor countries. The pilot AMC is designed to provide assurance to vaccine manufacturers that funds will be available for poor countries to buy vaccines for pneumococcal diseases at a predictable, long-term price.
27. HNP led a team of experts and partners to design a practical and implementable global copayment mechanism that would subsidize the purchase of artemisinins in both the public and private sectors. This mechanism is based on a proposal by Nobel Laureate Kenneth Arrow and colleagues at the Institute of Medicine who noted that, in addition to saving lives, the mechanism would delay the onset of resistance to artemisinins, creating a public good benefit for all.
28. World Bank (2006), *Repositioning Nutrition as Central to Development: A Strategy for Large-Scale Action*, Washington, DC: World Bank.
29. World Bank (2008), "Global Financial Crisis: Responding Today, Securing Tomorrow." Background Paper prepared by the World Bank Group for the G20 Summit on Financial Markets and the World Economy, Washington, DC.
30. HNP's response is focusing on addressing malnutrition, especially in light of the current crisis. The food security agenda is being addressed through parallel efforts, via ARD and the Global Food Crisis Response Program (GFRP), for instance. Of the contingency funds, 80 percent will be used to scale up the Bank's work on social safety nets and nutrition by providing regional operational support. The remainder will be used for other Bank-wide activities such as knowledge management, results monitoring, and partnership building.
31. The efforts at scaling up nutrition will complement the HSS agenda and the scaling up of social safety nets, thereby bringing to bear the Bank's multisectoral inputs.
32. Of the 33 high-fertility (TFR>5) countries, 31 are in Sub-Saharan Africa.

33. Gwatkin, D.R., S. Rutstein, K. Johnson, E.A. Suliman and A. Wagstaff (2004). *Socio-Economic Differences in Health, Nutrition, and Population*, Washington, DC: World Bank; Gwatkin, D.R., A. Wagstaff, and A.S. Yazbeck (2005). *Reaching the Poor with Health, Nutrition, and Population Services*, Washington, DC: World Bank.
34. The Strategy called for a balance between health specialists and economists/health systems specialists.
35. However, projects with a disease focus also include HSS components.
36. SPN: Supervision; LEN: Lending; ESW: Economic and Sector Work; TAS: Technical Assistance.

THE WORLD BANK